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THE UNIVERSITY OF ALBERTA

EMPLOYEE ASSISTANCE PROGRAM: THE SUPERVISOR'S PERSPECTIVE

by

© **ALFRED J. RIEDIGER**

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PHILOSOPHY

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DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled **Employee Assistance Program: The Supervisor's Perspective** submitted by **Alfred J. Riediger** in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Counselling Psychology.

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ABSTRACT

The purpose of this study was to describe the attitudes and opinions of supervisors with regard to the concept of employee assistance programming. This was considered important because program implementation depends primarily on the supervisor and because the program is still in an early stage of development and serious shortcomings have not yet been overcome.

One hundred forty-five supervisors from six employing organizations which have employee assistance programs were asked for their views through group administration of a questionnaire, followed by individual interviews with a random subgroup. A critical review of the literature had suggested that employee assistance programs are severely underutilized because they do not meet the supervisor's needs and are not adapted to the realities of the work place. It was also hypothesized that the effectiveness of such programs is severely limited because they fail to provide adequate coordination between the work place and the treatment agency.

The study substantiated the above concerns. It was found that supervisors are aware of a large number of problem employees but choose not to use the program in most cases. They reject the formal, coercive method of motivation and do not appreciate the program's relevance to work performance problems nor the validity of treatment in such situations.

The following major recommendations were made:

1. All behavioral health problems should be included in the program's scope.
2. The program should be primarily directed at resolution of the supervisor's dilemma in dealing with problem employees.

3. The program should provide professional consultation to supervisors and serve as a helping resource offered by the supervisor to the problem employee.

4. The motivational potential of the work place should be utilized to reinforce the problem employee's responsibility to accept help, without defining discipline as a program function.

5. A professional diagnostic and referral service should be provided to implement recommendation number three above and to coordinate the treatment agency with the work place.

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CHAPTER I

STATEMENT OF THE PROBLEM

Employee assistance programs are being actively promoted throughout North America as a solution to pervasive health and performance problems in the work place. However, many areas of ambiguity and controversy are associated with ongoing changes in the definition and application of such programs. Practical research is needed to assist in the development of a cohesive and viable program concept if the apparent potential of such programs to resolve employee problems is to be fully realized.

CONCEPT OF THE EMPLOYEE ASSISTANCE PROGRAM

Employee assistance programs are based on the idea that the work place, and particularly the employer-employee relationship, can be effectively utilized to identify problem employees and motivate them to seek treatment. It is assumed that poor work performance often results from problems which are treatable and that treatment is effective in resolving such problems and restoring the employee's work performance to an acceptable level. This general concept is supported by most writers in the field (Wrich, 1974; Lotterhos, 1975; National Counsel on Alcoholism~~, 1975~~; National Institute on Alcohol Abuse and Alcoholism, 1976; Roman and Trice, 1976). However, major differences have evolved in terms of emphasis and application of this concept.

Early programs were based on concern over the incidence and cost of alcoholism. The supervisor was expected to notice symptoms of alcoholism and threaten the employee with job loss in order to overcome his denial of the problem and motivate him to accept treatment–usually through Alcoholics Anonymous. This technique was reportedly successful in reducing the costs associated with employee alcoholism (Lotterhos, 1975; NCA, 1975).

Because of numerous problems associated with these early programs, the initial ideas were significantly revised during the 1960's. Instead of looking for symptoms of alcoholism, supervisors were encouraged to simply document poor work performance which was considered to be indicative of alcoholism. However, this led to recognition of non-alcoholic problem employees. This in turn resulted in a shift from alcoholism programs to troubled employee programs (NIAAA, 1973; Lotterhos, 1975). Some programs, however, considered the term "troubled employee" as simply a euphemism for "alcoholic" (Tucker, 1974; Rowntree, 1976).

From the seemingly minor change in program methodology noted above have evolved two strongly opposing schools of thought, i.e., alcoholism versus broad brush programming. The difference in perspective has important implications for every aspect of the programs—including their purpose, policy, rationale, procedures, and their organization or structure. A practical consequence has been the development of a wide diversity of programs with no clear identity and often lacking internal consistency. However, in view of the widespread acceptance of the fundamental program concepts noted above, the study treats all of the various specific types of programs as variations of the employee assistance program concept.

KEY ROLE OF THE SUPERVISOR

Because of the central importance of the employer-employee relationship most writers acknowledge and emphasize the key role of the supervisor because he is the most immediate representative of the employer to the employee (Trice, 1969; NCA, 1972; Sadler and Horst, 1972; Heyman, 1976). Consequently, the supervisor carries the major responsibility for utilizing the program policy and implementing its required procedures. These functions include identification of problem employees, motivation of problem employees and referral to treatment. It is generally assumed that the supervisor should be willing and able to carry out these functions because a) they are part of his normal role as the employer's representative, b) all of the needed resources are available as part of the work place and c) the quality of the program merits complete acceptance and trust by the supervisor.

The supervisor is expected to identify problem employees through his normal monitoring of their attendance and performance. When an employee's performance falls below the established standards of the work place and does not respond to normal corrective action the supervisor must assume that the employee is suffering from some sort of personal or health problem.

The problem employee is then confronted with his inadequate performance and threatened with ultimate dismissal unless he is willing to seek treatment and overcome the problem. This process is referred to as "constructive coercion" or, more recently, "constructive confrontation".

If the employee is willing to seek help the supervisor is required to channel him to a source of treatment. Most programs recommend that the company's medical department be utilized as a primary resource in this step.

It should be noted that the three steps listed above are endorsed as key program elements by writers advocating all of the various program types. These steps parallel the basic rationale of the program. This reinforces the importance and responsibility of the supervisor's role in the program. It is particularly significant, therefore, that the supervisor has been almost totally neglected in research on the program and has generally had no voice in the design or implementation of programs.

SHORTCOMINGS OF EMPLOYEE ASSISTANCE PROGRAMS

The employee assistance program concept is often publicized as a highly successful method of saving money for employers and rehabilitating "troubled" employees. A number of writers, however, have begun to identify problems and shortcomings in relation to many aspects of the programs.

A number of concerns relate to the controversy over the basic concept and rationale of the program itself (Cutler and Jones, 1976; Roman and Trice, 1976). Employee assistance programs are sponsored and promoted by various interest groups with differing perspectives. This has led to controversy over the validity and priority of various and potentially conflicting program goals. The great diversity of current programs reflects the lack of a consistent, comprehensive program rationale. Much of this diversity stems from reliance on untested assumptions and will need to be resolved on the basis of sound research. However, very little research is available other than a number of preliminary investigations concerning success rates and cost savings. Even these data provide little basis for generalization because of the idiosyncratic nature of the various programs. Trice (1977) has candidly stated, "The simple truth is . . . good data on any aspect of occupational programs is relatively nonexistent (p. 2).

Serious shortcomings are also becoming evident in terms of the program's acceptance in the work place. Booz *et al.* (1975) note that "Although alcoholism costs industry billions of dollars, the number of self-generated industrial programs has been minute (p. 13). A number of writers have also noted that in spite of intensive promotional efforts, only a very small percentage of employers have adopted programs at all and, of those who have adopted programs, only a small percentage have implemented the programs fully and effectively (Von Wiegand, 1975; Booz *et al.*, 1975; Trice, 1977).

In terms of program effectiveness a number of writers have questioned the validity of studies reporting high success rates (Edwards, 1975; Schlenger and Hayward, 1975; Roman and Trice, 1976). Another critical but somewhat neglected area of concern relates to the extent to which programs are actually utilized. It appears that even fully implemented programs are being applied to only a very small percentage of the problem employees in the organization (Sherman, 1976; Von Wagner, 1978). When these factors are taken into account it must be concluded that most employee assistance programs have only a minimal success rate.

In view of the above it would appear that a critical shortcoming of employee assistance programs is their failure to become operational at the level of the relationship between the employee and the supervisor. Most writers have responded to this issue by recommending additional training for supervisors and some have recommended that supervisors be fired for failure to use the program (Keefe, 1973). However, Trice (1971) had cautioned that the program must be designed primarily for the benefit of the supervisor on the assumption that supervisors would readily use the program only if they perceived this to be in their own best interests.

> . . . a policy can be more effective if its main target is frankly recognized to be the relief and aid of the immediate boss of an alcoholic employee, plus helping the employee himself. In a very realistic sense these two make up the "hard core" of resistance to a policy. All other parts of a program lead up to these two people . . . . Since the supervisor bears the brunt of the alcoholism problem in an employee, he is the one who will or will not decide to use the policy (p. 23).

OBJECTIVES OF THE STUDY

The success of employee assistance programming relies very heavily on the supervisor's willingness and ability to fulfill the functions assigned to him. The weaknesses and shortcomings of such programs make necessary a re-evaluation of the supervisor's role in relation to the entire program concept. Because the supervisor's role in the program is based on a large number of untested assumptions it seems reasonable to examine not only how the supervisor fits into the program but, also, how the program affects the supervisor. Because of the lack of data on this topic and the surrounding ambiguities concerning the program itself, the objectives of this study must be expressed in two stages.

The first objective is to identify key issues relating to the structure and dynamics of employee assistance programs. A critical review of the literature focuses on the program's purpose, its policy and rationale, its methods and procedures as well as its organization and administration. An attempt is made to relate these critical factors to the role of the supervisor.

The main objective of the study is to provide a description of the supervisor's attitudes and opinions with regard to the key program issues identified in stage one. The supervisor's perspective is then compared to a variety of assumptions on which the program is based. This hopefully provides a basis for conclusions and recommendations designed to create a better "fit" between the supervisor and the program.

IMPORTANCE OF THE STUDY

A variety of employee assistance programs are being actively promoted throughout North America and elsewhere. Therefore, the quality of such programs has important implications for many employees. Such programs have already demonstrated the potential to provide personal, social and financial benefits by providing a mechanism through which the work place can deal realistically and effectively with its "troubled" employees. However, further study is needed if this potential is to be fulfilled.

There is also some urgency in providing a basis for further program development. Roman and Trice (1976) note that

> .... Program design and development has proceeded without a firm research base. ... Since the effort has had to operate without this research base during the major phase of its development, it is likely that

> many assumptions will become embedded and vested interests developed, making research-based change difficult (p. 514).

Because Canadian programs have a shorter history and appear, at this point, to be subject to fewer "vested interests" it is particularly important that every effort be made to design the best programs possible at an early date.

Several writers have also voiced the concern that employee assistance programs will prove to be only a passing phenomenon unless basic shortcomings are quickly overcome. Recently, Bennett (1978) stated

> It would appear that the occupational programming movement has reached a plateau in its development in terms of 1) actual impact on employees' problems within organizations which currently have programs or 2) by extension of programming to the many organizations which do not have programs (p. 6).

Cutler and Jones (1976) in a study of occupational alcoholism programs in British Columbia express concern that occupational programs have shortcomings which may lead to their ultimate demise. They conclude that

> The apparent strength of the movement today may, within the next three or four years, dissipate to the point where the only evidence of the movement is found in messages from public relations departments (p. 29).

Trice (1977) issues a similar warning.

> All things considered, the 'state of the art' in industrial programming is one of demonstrated potential, given reasonable effort and improvements. . . . However; unless future efforts reduce the glaring flaws of the past few years . . . the strategy could become a footnote in the history of efforts to deal with alcoholism and other drug abuses (pp. 5 and 6).

On a more positive note, the study is also important because of the broader positive implications of employee assistance programming. Such programs represent an initial and innovative effort to foster a partnership between the work place and the treatment agency. Many issues encountered in these programs may well serve as a model for coordination between the work place and health service delivery systems in general. Consequently, careful consideration is warranted regarding the characteristics of both the treatment programs and employing organizations and especially of the interface between the two.

DEFINITIONS

Employee assistance programs are characterized by controversy and ambiguity with regard to their concepts and terminology. In this section the common usages of key terms will be presented together with a definition of the term for purposes of this study.

Employee Assistance Program

This term is the product of an evolution from occupational alcoholism programs to troubled employee programs and broad brush programs. In some cases "employee assistance" is used as a less obvious designation for occupational alcoholism programs. In other cases the term is intended to differentiate between programs designed for alcoholic employees and programs designed to serve employees with any behavioral/medical problem. Because all of the above programs have a common basic rationale, the term is used in this study to designate the variety of programs which utilize the employer-employee relationship in order to identify problem employees and motivate them to accept treatment with a view to restoring adequate work performance. In these programs the supervisor is typically required to utilize work performance criteria to identify problem employees, confront them with the threat of ultimate dismissal and refer them for treatment if they are willing to accept.

Troubled Employee Program

This term came into use as a result of recognition that identification of problem employees on the basis of work performance was resulting in identification of employees whose problems were not necessarily alcohol related. The term is used to designate programs which focus entirely on alcoholism, programs which focus on alcoholism and related problems, as well as programs which focus on a variety of employee problems.

Broad Brush Programs

These programs utilize the basic alcoholism program approach but specifically include alcohol-related problems as well as non-alcohol-related problems as their area of concern.

Work Performance Problem

This term is defined here as any ongoing decline in work performance or attendance below acceptable standards or any marked decline in work performance from the employee's regular or potential level.

Problem Employee

This is an employee who has a work performance problem.

Troubled Employee

This term was originally coined as a euphemism for "alcoholic". It has come to mean any employee who has a problem which results in impaired work performance.

Behavioural Health Problem

This term is used here to designate a variety of health-related problems which are potentially a cause of work performance problems. They are defined as any mental, emotional or physical problem (including alcoholism or drug abuse and reactions to situational stress) which may impair the individual's ability to function effectively.

Alcoholism

Edwards (1975) notes that there is no common definition of this term. The American Medical Association defined alcoholism as a disease in 1956. Most writers on employee assistance programs endorse this concept, noting that this concept has helped to reduce the stigma of alcoholism and make medical benefits available to alcoholics. However, numerous writers challenge the disease concept (Cahalan, 1969; Roman and Trice, 1968; Seeley, 1962; Steiner, 1969; Davies, 1974; Robinson, 1972). Many writers suggest that a socio-cultural model of alcoholism as deviant behaviour provides a more realistic basis for occupational programs (Roman and Trice, 1976; Trice, Beyer and Hunt, 1978; Trice and Beyer, 1977; Moore, 1973; O'Bryant *et al.*, 1973).

Few writers in this field provide a specific definition of alcoholism. Trice (1969) and Asma (1975) suggest that "alcoholism can be defined as 'habitual poor job performance resulting from excessive drinking' " (p. 179).

Robinson (1972) points out that "Jellinek's original definition of the disease concept of alcoholism was restricted to the loss-of-control and inability-to-abstain aspects of excessive drinking" (p. 1028). However, he later used the term to refer to "any use of alcoholic beverage that causes any damage to the individual or to society" (p. 1030).

For purposes of this study the definition suggested by Plaut (1967) is utilized which defines alcoholism as ". . . the repetitive use of alcohol which results in physical, psychological or social harm to the drinker or others" (quoted from Cahalan and Room, 1972). It should be noted, however, that a variety of definitions are utilized by the various writers who are quoted or referred to in this study.

Constructive Coercion

This technique originates from AA philosophy and is considered a primary method of motivating problem employees to accept treatment through the exercise of legitimate discipline. The method consists of a threat of job loss if the problem employee fails to accept treatment and restore adequate work performance. The importance of the job to the employee is considered a major factor in breaking through his denial and persuading him to accept treatment. A variety of synonyms have been developed for this term. The most popular one currently is *constructive confrontation.*

Immediate Supervisor

This term is defined to include any supervisor of employees who is directly responsible for maintaining work standards, evaluating performance and initiating disciplinary action if necessary. This includes both front line supervisors as well as senior managers who have supervisory responsibilities toward their immediate staff.

Indirect Supervision

This includes a senior supervisor's responsibilities toward junior staff whose immediate supervision is the responsibility of intervening levels of supervisors. In addition, it includes responsibility toward employees in some particular capacity other than as line staff.

Regular Staff

This is defined as permanent, full-time employees in normal positions (i.e., as opposed to informal or contractual arrangements).

ORGANIZATION OF STUDY

The general rationale for the study has been presented in this chapter. In Chapter II the historical development and current status of employee assistance programs are summarized and existing research findings are reviewed. Special attention is given to the relationship between employee assistance programs and occupational mental health and to the program's development in Canada. Chapter III includes a critical review of the rationale for employee assistance programs and a more specific description of the problem under study.

The methodology utilized in the present study is described in Chapter IV. This is followed by a presentation of findings in Chapter V. The data are presented in two sections; firstly, for the total sample group and subgroups representing the participating employers and secondly, for several comparison groups classified according to criteria thought to be associated with differences in utilization or perception of the program by supervisors. An attempt is made to present the data in the context of their implications for the program concept. Finally, a number of conclusions and recommendations concerning the concept of employee assistance programming are suggested in Chapter VI.

CHAPTER II

THE DEVELOPMENT OF EMPLOYEE ASSISTANCE PROGRAMS

The literature on employee assistance programs tends to be fragmented, inconsistent and incomplete. Most of the literature and research is directed toward alcoholism and neglects the broader issues of behavioural health problems, the nature of the work place and the quality of treatment.

> The literature on occupational alcoholism is twofold: (1) reports, investigations, and evaluations of occupational programs; and (2) research into the problem of alcohol misuse by employed persons (Archer, 1977, p. 3).

Further, much of the emphasis has been on program promotion and descriptions of specific programs and concerns. Much of the existing literature is widely dispersed and informally published. Harrison M. Trice, Professor of Industrial and Labor relations at Cornell University, is undoubtably the most prolific and well established writer in this field. In association with a number of others, notably Paul Roman, Professor of Sociology at Tulane University, Trice has provided the most comprehensive treatment of the program's conceptual implications. Therefore, his works are utilized extensively in this review as a basis for integrating the various views presented by numerous other writers.

In this chapter a review of the development of the program concept is presented. The program's origins are presented in terms of its historical development, the dissemination of programs and a description of model programs and program elements. A discussion of the current state of affairs includes the diversity of programs, research and evaluation, the program's relationship to occupational mental health and a review of the program's development in Canada. Finally, a number of key issues are identified with regard to the program's future development. It should be noted that the word "program" is used to designate the overall concept of employee assistance programming except where the context clearly indicates a particular program.

HISTORICAL DEVELOPMENT OF THE EMPLOYEE ASSISTANCE PROGRAM CONCEPT

INITIAL PROGRAMS (1944–1960)

Employee assistance programs have their roots in the industrial alcoholism programs which were pioneered in the early 1940's. The first industrial programs were established by DuPont and Eastman Kodak in 1943 and 1944, respectively (Lotterhos, 1975; Cutler and Jones, 1976). Other early programs included Allis Chalmers, Consolidated Edison, Equitable Life Assurance Society and Kemper Insurance (Archer, 1977; Roman and Trice, 1976).

Roman and Trice note that these early programs almost always originated in the medical departments of large companies and most of the necessary counselling and treatment were provided intramurally. Consequently, the programs were highly medically oriented and avoided the issues of health insurance coverage and adequate referral resources.

Booz *et al.* (1975) state that these early programs relied on the observation and diagnosis of the immediate supervisor to identify and refer alcoholic employees.

> Using the stereotype of the skid row derelict, an employee who showed shaking hands, alcohol breath, bloodshot eyes, loud and obnoxious behaviour and personal deterioration would be labelled alcoholic (p. 2).

They note that treatment usually consisted of detoxification and/or referral to Alcoholics Anonymous. These early programs were considered quite effective and reported that significant numbers of identified alcoholics were able to return to their jobs and perform adequately.

The Yale Center of Alcohol Studies was formed in 1941 and served to focus scientific interest on the condition of alcoholism. The National Counsel on Alcoholism (NCA) was established in 1944 and from its inception promoted the establishment of alcoholism programs. Alcoholics Anonymous (AA) which had been founded in 1935 served as a primary resource to the program and as an example of the alcoholic's potential for rehabilitation. The efforts of AA were instrumental in the American Medical Association's decision in 1956 to define alcoholism as a disease (Archer, 1977).

Roman and Trice (1976) note that early programs were oriented toward the medical condition of alcoholic employees rather than toward personnel management. They note that the supervisor's confrontation of the alcoholic was defined as a modification of the AA concept of "hitting bottom" as a necessary prerequisite for motivating the individual to do something about his problem.

> In the confrontation, a clear statement is made to the effect that failure of the employee to take action about his problem and improve his performance would lead to discipline or even dismissal (p. 463).

They emphasized that this confrontation was coupled with the offer of treatment assistance.

BASIC CHANGE IN ORIENTATION (the 1960's)

In 1960, because of slow growth in company programs, the NCA recruited a number of management consultants to promote the implementation of programs by more employers. The Christopher D. Smithers Foundation also became involved in occupational alcoholism during this period. The foundation's support was instrumental in the creation of the program on alcoholism and occupational health in the New York State School of Industrial and Labor Relations at Cornell University (Archer, 1977).

In addition to its promotional efforts, the NCA through its labor-management services department, conducted a number of surveys of employee personnel records in a number of large corporations in order to find a more effective way of identifying alcoholic employees and referring them for treatment at an earlier stage in the illness. On the basis of these surveys the NCA concluded

> Every employee who is suffering from alcoholism, even in its early stages, will have a deteriorating pattern of job performance which is readily observable by any reasonably alert supervisor (Von Wiegand, 1974, p. 83, quoted from confidential studies in the files of the NCA).

Von Wiegand notes that

> This pattern is manifested through such objective factors as absenteeism, poor judgment, erratic perfomance, excessive material spoilage, decreasing productivity, poor interpersonal relationships, lateness and early departures, customer complaints, failure to meet schedules, and countless other instances of poor performance (p. 83).

The discovery of a relationship between poor job performance and alcoholism suggested the possibility of early identification of alcoholic employees and

> . . . led to the crystallization of a new methodology which . . . consists of a system which focuses exclusively on monitoring job performance. Under this system all employees whose performance drops below acceptable standards, and where regular corrective procedures fail to re-

> store acceptable performance, are referred to professional counselling and diagnostic services for identification of the employee's problem, followed by treatment appropriate to whatever the employee's problem is (pp. 83 and 84).

In addition, this approach differentiated between management and treatment functions and limited the supervisor's role to managerial rather than clinical responsibilities.

As a consequence of this basic program change a number of secondary developments began to occur. The focus on work performance problems led to identification and acknowledgement of problems other than alcoholism. A number of programs became known as "troubled employee" programs. This, in turn, led to the development of broad brush and comprehensive employee assistance programs.

DISSEMINATION OF PROGRAMS

From their inception employee assistance programs have relied heavily on the promotional efforts of various organizations to introduce the concept into new employment situations. Most of these promotional efforts have been sponsored by what Trice refers to as the "alcoholism industry". Consequently, a strong emphasis on alcoholism continues to characterize this entire field.

Organizations Involved in Program Promotion

As noted previously, the founding of AA was a contributing factor to the development of early occupational alcoholism programs. As an organization, AA explicitly avoids involvement in treatment or promotional programs. However, individual members have been a major force in the development and staffing of occupational programs (Lotterhos, 1975; Roman and Trice, 1976; Wrich, 1974). Roman and Trice note that this interpenetration of AA into occupational programming has contributed to a high level of enthusiasm and zeal and has established a pattern of nonprofessional staffing and ideology.

The National Council on Alcoholism was founded in 1944. This is a voluntary organization supported primarily by private donations and grants. The NCA's labor-management services department is a strong advocate of joint union/management alcoholism programs. The NCA publishes the *Labor-Management Alcoholism Journal.*

The Christopher D. Smithers Foundation has actively supported research, training and publications focusing on occupational alcoholism since the late 1950's. The

Foundation supported the development of a program on alcoholism and occupational health in the New York State School of Industrial and Labor Relations at Cornell University which is headed by Harrison M. Trice.

The program on alcoholism and occupational health at Cornell University was begun in the mid-1960's. The Cornell program sponsored a series of training conferences on occupational alcoholism and published *The Problem Drinker on the Job* for widespread free distribution in 1959. This resulted in greatly increasing the awareness of the personnel management community about occupational alcoholism program concepts. Roman and Trice (1976) note that the Cornell program's research and training efforts contributed to the emergence of a strong emphasis on union involvement in occupational programs and to the development of the problem employee concept as an alternative to the narrow alcoholism focus of earlier programs.

The Alcohol and Drug Programs Association of North America (ADPA) consists of a wide range of workers in the field of alcoholism and drug abuse. The organization presents information concerning the development and execution of alcohol and drug programs at an annual meeting. In addition it serves as an informal clearing house for the diffusion of pertinent information. The organization's involvement in occupational programming has expanded significantly in the past several years.

The National Institute of Alcohol Abuse and Alcoholism (NIAAA) was established in 1970 by the passage of the Hughes Act. This government agency has had the greatest influence on program development and is discussed under a separate heading below.

The association of Labor and Management Administrators and Consultants on Alcoholism (ALMACA) was formed with encouragement from NIAAA. ALMACA is a professional organization which serves consultants and administrators in occupational programs. It sponsors an annual conference and attempts to consolidate the identity of program personnel and increase the visibility of occupational programs.

A similar but smaller organization consisting primarily of state occupational program consultants is the Occupational Program Consultants Association. It has functioned largely on an informal basis and is considered somewhat redundant (Roman and Trice, 1976).

The Addiction Research Foundation of Ontario (ARF) appears to be the primary source of research and promotional activities in Canada with regard to occupational programming. The ARF specifically promotes a comprehensive employee assistance program concept.

The Canadian Addictions Foundation has also explored the concept of occupational programming in recent years. However, the primary responsibility for program promotion throughout this country appears to rest with provincial alcoholism foundations and commissions. Many of these organizations include a distinct occupational sub-program.

Program Growth to 1970

By 1959 it was estimated that no more than fifty companies had implemented formal alcoholism programs (Archer, 1977). In the following year the NCA launched a major promotional effort through recruitment of a number of management consultants. A survey by Habbe (1968) included 160 companies which were thought to have a program. Of these, only 27 indicated that they had a fairly good program. Trice (1977) reports that well over 100 corporations had such policies in operation in 1970. A survey of over 300 company programs in 1971 resulted in the conclusion that only twelve programs were successful and efficient. Booz *et al.* (1975) state that "prior to NIAAA's funding activities in 1972, there were eleven public sector occupational alcoholism programs and 188 private" (p. 4).

It is evident that the dissemination of occupational alcoholism programs has not been adequately documented. In general, it appears that the spread of programs was very slow before 1960 and experienced a small upsurge in the 1960's. However, prior to the formation of the NIAAA very little dissemination had occurred. Additionally, it is evident that most of the nominally existing programs were considered grossly inadequate. These early efforts had, however, gained widespread recognition for the concept of occupational alcoholism programming. This became a significant factor in the enactment of the Hughes Act in 1970.

The Hughes Act (NIAAA)

The NIAAA was created by the enactment of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, of Public Law 91-616, by the 91st Congress on December 31, 1970. This legislation came to be known as the Hughes Act after its sponsor, Senator Hughes. The act transformed the National Center for Prevention and Control of Alcoholism into the National Institute for Alcohol Abuse and Alcoholism. A five-year budget of $300 million was allocated to the NIAAA. The Occupational Programs Branch was created in 1971. The NIAAA was originally part of the National Institute of Mental Health (NIMH). In 1973 the NIAAA, NIMH and the National Institute of Drug Abuse were linked to form the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA).

In 1971 the NIAAA developed a temporary network of thirty consultants who had some prior experience in occupational alcoholism programming. These consultants were made available to work organizations desiring assistance in implementing programs. In 1972 the Occupational Programs Branch made available a $50,000 per year, three-year demonstration grant to each state and territory. These grants were to be used to hire two consultants whose purpose was to develop occupational programs for employing organizations. One consultant was to serve the private sector and the other served the state and local governments. Only three states or territories failed to obtain these grants.

The consultants hired under this program represented a very wide range of prior experience. In order to provide a basic level of knowledge and some standardization of procedures, the Occupational Programs Branch funded a grant to form the National Occupational Alcoholism Training Institute (NOATI) at East Carolina University to provide training for the consultants. However, Roman and Trice (1976) note that "to a very large degree, the consultants felt frustrated by the absence of hard information on which to base their diffusion efforts" (p. 467). They also note that the consultants were often frustrated because appropriate treatment facilities were often unavailable or they were inappropriate because they were designed to serve the public inebriate type of alcoholic.

The Occupational Programs Branch also has supported approximately forty demonstration projects that are designed to compare various types of service delivery systems for reaching employed alcoholics. Approximately half of the states have assumed responsibility for funding the program consultants after the three-year grants ended.

Program Growth Since 1970

The establishment of the NIAAA has served as a major factor in program dissemination. There is considerable confusion, however, concerning both the number of programs in existence and the number of organizations potentially requiring programs. Roman and Trice (1976) state that over 900 American employers have developed policy and procedure statements since the federal grants for consultation services were made in 1972. However, Trice (1970) estimates that only 300–400 larger companies have programs and less than 600 well-implemented programs exist in total in the United States. This is compared to an estimate that nearly 500,000 work organizations employ 100 or more persons.

Von Wiegand (1974) noted that of 1,600,000 American corporations only 300–400 have adopted some form of alcoholism program. Of these, less than 25 are considered to be achieving "anywhere near their possible potential" (p. 5). Cloud (1977) estimates that of 1,800,000 employer organizations, not more than 1200 have any sort of alcoholism program. Rooney (1978) estimates that there are 12 million business organizations in the U.S. that could use occupational services, including corporations, partnerships and privately owned businesses. He estimates that 4,000–5,000 occupational programs exist.

These estimates indicate that program growth has been greatly accelerated in the mid-1970's but that the concept is still very far from being widely accepted. There is also cause for concern that the increase in number of programs does not reflect an increase in the number of good programs.

DESCRIPTION OF PROGRAMS

MODEL PROGRAMS

The Yale Plan

The Yale Plan (Henderson and Bacon, 1953) is directed toward industry's failure to recognize alcoholism as a problem in the work place. Barriers to such recognition include: the misconception that alcoholism is a moral degeneracy, the stereotype of the alcoholic as a skid row "bum", resentment over invasion of the alcoholic's privacy and a lack of documentation of the extent of alcoholism. The major obstacles to initiating a program include objections from labor, fear of bad public relations, concern over costs of the program and rejection of responsibility by business and industry. Henderson and Bacon argue that the costs of alcoholism are hidden. Many of these costs are associated with the "half man" in industry who performs less efficiently because of a hangover. The Yale Plan consists of the following steps.

1. Management must accept alcoholism as a health problem.
2. Program responsibility shoud be assigned to the medical, personnel, or employee relations divisions.
3. A program supervisor should be selected.
4. A program supervisor should mobilize existing resources such as the medical department, industrial nursing staff, a plant counsellor, a legal department, a credit union, etc.
5. As the rehabilitation service is developed a constructive plant policy should be formulated concerning severance, discipline, treatment, etc.
6. Counselling and referral services should be established to identify the alcoholic employee, to interpret to him the nature of his problem and the possibility of recovery and to refer him for rehabilitation.
7. Supervisors and administrators should be trained so that they can act as a liaison between the employee and the plant program.
8. Plant personnel should be taught to diagnose alcoholism.
9. An in-plant survey should be used to determine the incidence of alcoholism (Henderson and Bacon, 1953).

The Yale Plan is intended to provide early intervention and is viewed as a preventative program.

National Counsel on Alcoholism

The NCA (1975) advocates a joint union-management approach. The primary objective is the provision of effective assistance and treatment to alcoholics. Identification of alcoholic employees is made on the basis of impaired work performance.

The development of a program includes a joint policy statement, establishment of joint union-management committees at the company-wide and local plant levels and an outline of a procedure for case handling. The company is asked to provide a full-time program administrator to implement the committee's decisions. A primary concern of the program is the equal distribution of decision-making authority between union and management. Co-ordination between work place and treatment resource is largely neglected but the joint committee is encouraged to survey community alcoholism treatment facilities as a basis for referral.

The Christopher D. Smithers Foundation–H. Trice

The Smithers Foundation (Trice, 1971) advocates a program which is alcohol oriented but provides a basis for subsequent employee assistance programming as well. Trice argued that the world of work has a legitimate role in the rehabilitation of alcoholics because

1. the structure and standards of the work place provide a basis for detecting alcoholism at an early stage,
2. the importance of adequate work performance gives the employer a mandate to take constructive action,
3. the employer can motivate the employee to accept treatment by threatening dismissal,
4. the supervisor should be highly motivated to confront the alcoholic because the supervisor is responsible for adequate production.

Necessary program components include a clear personnel policy, availability of suitable therapy, adequate training of supervisors regarding identification, willingness of the supervisor to utilize the program and willingness by the alcoholic employee to accept treatment. Trice emphasizes that one of the primary goals of the program should be to assist the supervisor of the alcoholic employee. The supervisor is responsible for identifying the alcoholic employee and referring him for treatment or discharging him if necessary. Trice emphasizes that

> Coordination between line supervision and treatment must be firmly lodged in some well established unit. This unit will receive referral cases from immediate supervision, decide on treatment type and routing, and tell the immediate boss the prognosis. It will process the treatment, whether it be in company or outside, and report to the immediate supervisor whether he could expect improvement and how much (p. 25).

National Institute on Alcohol Abuse and Alcoholism

The NIAAA program (1976) is based on a survey of relatively successful American programs. The program stresses the supervisor's role in observing and documenting deteriorating work performance and referring the troubled employee to a unit which may be called an "employee counselling service or employee assistance service". The purpose of this management service is to

> . . . ascertain what is troubling the employee to the detriment of his work performance, and, having done so, to put the employee on a course of action designed to deal with his problem or problems (p. 8).

The program stresses the availability, appropriateness and acceptability of treatment resources and the close coordination between the work place and treatment. The program calls for a professionally trained staff in the counselling unit. It also implies that identification and referral of problem employees are the primary program-related functions of a supervisor. The threat of job loss is considered a normal management function and not a central concern of the program. Union-management cooperation is recommended, primarily at the plant level.

Hazelden Foundation–J. Wrich

Wrich (1974) proposes an employee assistance program concept as an alternative to the earlier "supervisory identification approach". He notes that the earlier approach experienced problems because only first-line supervisors were usually trained to diagnose alcoholism with the result that no senior employees were identified. In addition the program often took on the appearance of a "witch hunt" which resulted in increased efforts at denial of the problem. Finally, he notes that alcoholic people are very skillful at avoiding identification.

> When matching a supervisor with one or two hours' training in the symptomatology of alcoholism against a practising alcoholic who has stored up scores of excuses and alibis over the years, it was simply no contest–the supervisor lost nearly every time (p. 11).

Wrich notes that the term "the employee assistance program" is intentionally broad because a) the program is intended to assist employees regardless of the nature of their problem and b) alcoholic employees tend to avoid programs labelled "alcoholism or alcoholic". Wrich notes that in regard to alcoholic employees, the program's purpose is to

> . . . confidentially assist those 95% of the chemically dependent employed population who are not recognized by labor and management, as well as the 5% whose problems are so overt as to be apparent to virtually everyone (p. 13).

In order to achieve early identificaion of problem employees, the supervisor's attention is focused on job performance and attendance. Wrich notes that "this program is designed to cope with a wider range of human problems at an earlier stage because the initial identification is of a broader category–job performance." The effectiveness of this approach is considered to result from the earlier identification of problems and the motivating power of the employer's threat to dismiss the employee. Wrich notes that "the motivation to get help is often as important as the help itself" (p. 14).

The recommended implementation procedure for his program includes the following steps:

1. The program consultant initiates separate discussions with management and labor concerning the incidence and prevalence of problems affecting job performance.

2. The initial discussion is repeated with those individuals who have the authority to establish a program.

3. An inventory should be made of all available community treatment services and the employment setting should be surveyed so that the program can be tailored to suit the employment setting and coordinate its activities with the available treatment community.

4. A labor-management committee should be formed to develop a written policy and procedures. Additionally, the committee should monitor the functioning of the program for a period of time after its initiation.

5. An official diagnostic and referral resource should be designated.

6. A management and supervisory orientation program should be conducted. Suggested topics include: introduction, policy, supervisor's role, job performance, troubled employees, program benefits and an overview of the program.

7. The employees and their families should receive separate notification of the initiation of the program.

8. A plan for continuing education and training should be developed.

Addiction Research Foundation of Ontario

The Addiction Research Foundation of Ontario (undated) has provided the most widely publicized Canadian program model. It is explicitly defined as an employee assistance, rather than an alcoholism, program. The purpose of the program is to

> . . . assist all members of staff who may develop a problem affecting their job performance, and to aid them in gaining assistance before their condition renders them unemployable (p. 1).

The supervisor's responsibilities are to

1. note and document incidents of unsatisfactory performance,
2. conduct a corrective interview,
3. arrange for a follow-up interview.
4. If performance does not improve, give an employee a firm choice between accepting assistance or being subject to the usual discipline.
5. If the employee is cooperating with treatment but performance has not improved, apply normal disciplinary procedure.

ESSENTIAL PROGRAM ELEMENTS

Booz *et al.* (1975) define occupational alcoholism programs as follows.

> An occupational alcoholism program is any effort by an organization to identify and help its employees deal with alcohol-related job impairment in contrast to ignoring them or dealing with such impairment by disciplinary actions. "Programs" range from the promulgation of written policies on the subject of alcoholism as the total "program" to highly developed, internally staffed programs offering treatment services. The theme of all program efforts is to designate alcoholism as an employee health problem subject to the same considerations as any other illness (p. 1).

They go on to note that all such programs rely on four factors which include

> . . . early identification and confrontation, willingness to enter treatment, referral resources for treatment, union inducement and participation (in organized companies) . . . (p. 3).

Policy Statements

A clear statement of policy is generally considered a basic program requirement. Although these statements are variously worded they typically include the following basic elements. a) Behavioral health problems (or alcoholism only) are considered as treatable illness. b) The usual sickness benefits will be granted. c) The individual is expected to cooperate in seeking treatment. e) Continued poor work performance is subject to disciplinary action up to, and including, dismissal.

Additional policy statements which are frequently included are as follows: e) The employer will assist in obtaining adequate treatment. f) The employee's use of the program will entail no stigma with regard to job security or advancement. g) The employer's concern is limited to the effect of the health problem on work performance. h) Confidentiality will be maintained as for any medical records. i) The policy does not provide exemption from any standard personnel practices. j) The employee should seek early, voluntary treatment. k) The employer will provide staff training in program utilization.

The NCA (1975) advocates a joint union-management approach directed toward the effective handling of alcoholism. The development of a program includes the development of a joint policy statement, the establishment of joint union-management committees at the company-wide and local plant levels and the outline of the procedure for case handling. The suggested policy statement is similar to that summarized above but emphasizes protection of employee rights and encouragement of employees to seek voluntary treatment. Management's responsibility for disciplinary action within the contract is supported.

The joint committees are responsible for administration of the program. However, it is recommended that a full-time program administrator be provided by the company to implement the committee's decisions.

The procedure for case handling involves the following steps. a) The supervisor interviews the employee regarding his poor work performance. A union representative may be present. b) The worker is informed of confidential, professional services available. c) If the worker accepts, a referral is made directly to a qualified professional counselling and diagnostic facility. If the worker refuses referral, he becomes responsible to improve his performance on his own. d) If the performance problems recur, the employee may be offered a firm choice between accepting referral or discipline. e) If the employee continues to refuse help he is liable to normal disciplinary action under the existing agreement.

Program Components

Wrich (1974) lists the following key ingredients for a successful program.

1. A supervisor who has definite work performance standards; is capable of recognizing a job performance problem; is able and willing to record unsatisfactory work performance and call it to the employee's attention.
2. In organized plants a labor representative who through philosophy and orientation is known to have the employee's best interests foremost in mind.

> 3. A professionally competent diagnostic component to which troubled employees can be referred and which is capable of diagnosing a variety of problems as to cause, evaluating them, and referring the troubled person to the proper modality of care.
> 4. A continuum of care capable of dealing with troubled persons of all descriptions, about half of whom would be alcohol abusers.
> 5. System of records capable of measuring various definitions of success (p. 16).

Trice (1971) lists the following as necessary components of the occupational alcoholism program. A clear personnel policy with respect to alcoholism must be adopted. Suitable therapy must be available to the employee. The supervisor must have adequate information about early identification. The supervisor must also be willing to utilize the policy and the program. The alcoholic employee must be willing to accept treatment. Finally, the program must be given sufficient time to develop. Trice notes that all of these components are interdependent and need to be coordinated.

One of the primary goals of the program is to assist the supervisor of an alcoholic employee. Trice noted that it is management's responsibility to develop a policy and to explain it to the union, but later adopted a joint program concept. He states that managements tend to reject the invasion of decision-making rights by the union but points out that unions can stall application of the policy if they are hostile to the program.

The following policy statements are recommended. a) Senior management defines alcoholism as a health problem which requires therapy. b) The company offers assistance in securing therapy. c) If no noticeable improvement in work performance occurs, the employee will be dismissed. d) All levels of management will approve the policy and communicate it widely to their staff.

The supervisor is responsible for identifying the alcoholic employee and referring him for treatment or discharging him if necessary. He may refer directly to the medical department or through a representative of the personnel office. Trice stresses that one of these resources must coordinate the relationship between the supervisor and the treatment agency.

Archer (1977) identifies the following key features of successful programs.

> These include a written policy which states the procedures for identifying, confronting, and referring employees who may have a drinking problem. The policy should specify that its provisions are to be applied

> evenly throughout the work force, without regard to occupational status or position; it should specify the distribution of authority and responsibility involved in policy implementation, as well as the rights and responsibilities of workers with respect to alcohol use and abuse; and it should be disseminated throughout the work force to inform both supervisory and rank and file employees of the provisions and operation of the program and to encourage self referrals. Additionally, successful programs establish specific channels within the organization to discharge the policy. Although the first line supervisor most often initiates the confrontation, a program coordinator should be appointed, both to relieve the supervisor of the onus of total responsibility for handling a problem drinker and to provide specialized expertise in counselling and/or referral to treatment. Finally, supervisory and management personnel should be trained as to their responsibilities in implementing the policy, and union officials should be involved at all stages of program implementation. Because of the importance of cooperation and consent of the labor union to the effectiveness of any program involving employee welfare, joint union-management programs are seen as ideal, although they have been relatively rare to date (p. 5).

DIVERSITY OF PROGRAMS

The preceding history and description of programs illustrates the wide variation in programs which have been espoused by various groups and individuals. Almost every program element is the subject of some controversy (Ravin, 1975). The diversity of existing programs is further compounded by differences in setting, variations in emphasis, combinations of program elements from various sources and by incomplete implementation in the majority of cases. In this section an attempt is made to delineate some of the central themes around which programs differ.

PROGRAM TYPES

Existing programs have been categorized in a variety of ways. Trice (1977) classifies programs according to their target population. Thus, programs are seen in terms of a steady expansion of the definition of the target group. These include a) programs designed primarily to deal with alcoholism, b) expanded alcoholism programs which also deal with the side effects of alcoholism, c) programs which include alcoholism and other drugs, d) troubled employee programs which recognize problems not related to alcoholism or drug abuse and e) employee assistance programs which are not primarily alcohol oriented. Trice notes that "many report that nearly 50% of their clients are problem drinkers or alcoholics" (p. 7).

Program characteristics are greatly influenced by differences in purpose. Sponsoring alcoholism organizations view programs as a case finding mechanism in the fight against alcoholism (Von Wiegand, 1974). Employers are, in most cases, urged to view the programs as a means of reducing costs. Unions tend to consider the programs as a means of enhancing job security and as a health benefit. However, they also perceive such programs as a potential threat to employees' rights because management may utilize the program as a means of justifying termination of employees. Other program goals include enhancement of the supervisor's effectiveness and fulfilment of the employer's moral obligation to assist "troubled" employees.

The differences in purpose result in differences in the definition of the target population. Some programs are explicitly alcohol oriented (NCA, 1975), some provide for troubled employees but assume that the trouble is alcohol (Tucker, 1974), whereas some are concerned with any behavioral health problem (Addiction Research Foundation, Ontario, undated) and others include employees in a wide variety of practical difficulties (Weissman, 1976).

Program policies, as noted previously, tend to express a fairly consistent rationale for the existence of programs. However, the procedures employed to implement the policy vary widely. Identification of the problem employee is usually made on the basis of poor work performance. However, some programs rely heavily on voluntary self referrals (Jones, 1975) whereas others consider referral a supervisory or medical responsibility.

The motivation of problem employees to accept treatment is also a subject of controversy. Ravin (1975) notes that some programs emphasize their role in offering help whereas others emphasize their role in placing the employee under coercion to accept help.

The referral mechanism is also structured in a wide variety of ways. This program component is also notably underemphasized in most program descriptions. Some programs seem to expect the employee to find help on his own; some make this a supervisory responsibility or provide a program administrator for this task (Rowntree, 1976); others rely on joint union-management committees, company medical services, alcoholism counsellors, professional employee counselling services (in-house or through contract), and some programs provide comprehensive treatment services through the company (Schramm, 1977).

Great variation also occurs in program organization, both within the company itself and in relation to utilization of community resources. Wrich (1974) notes that many programs are designed to serve alcoholic employees but are attempting to apply their methods to all problem employees. Many programs rely entirely on nonprofessional staff whereas other programs emphasize the central role of a professional diagnostic and referral service. Consequently, some programs are closely coordinated with community treatment agencies whereas others consider treatment as a minor and somewhat isolated program function (Schramm, 1975; Archer, 1977).

A review of the above differences among programs suggests the following classification of broad program types.

Narrow Scope (Alcoholism) Programs

The most limited and traditional programs continue to deal only with alcoholism and utilize strongly coercive motivational methods. Provision of treatment is considered essentially external to the program and supervisors or other administrators are responsible for directing employees to treatment resources.

Comprehensive (Behavioral Health) Programs

These programs are specifically designed to deal with any behavioral health problem and provide diagnostic, counselling and referral services as an integral part of the program. Provision is made for employees to seek assistance voluntarily and the program is defined essentially as a resource to employees who have problems. The employee's obligation to utilize this professional service is reinforced by the normal disciplinary process. However, discipline is considered part of the work setting rather than as a central program element. The program is designed to provide effective coordination between the work place and the treatment agency throughout the entire process of motivation, referral, treatment and rehabilitation.

Mixed (Broadbrush) Programs

A large number of existing programs fall into this category. Many are nominally directed toward "troubled employees" but emphasize alcoholism. The program emphasizes the importance of treatment but primarily utilizes nonprofessional staff. Company medical departments are often utilized but do not consitute a central program element.

Varying degrees of coercion are utilized in motivating employees to accept treatment.

CONFLICT BETWEEN ALCOHOLISM AND EMPLOYEE ASSISTANCE APPROACHES

The central debate concerning the identity of occupational programs involves the conflict between narrow alcoholism programs and comprehensive assistance programs. Trice (1973) presents a summary of both points of view. He notes that alcoholism programs should logically include other forms of drug abuse because many people abuse both alcohol and other drugs. He also points out that most programs are funded by alcoholism organizations and most research and program development has been based on alcoholism. Consequently, there is little information available concerning the success rates for non-alcoholic problem employees. In addition, he notes that very few program counsellors are equipped to deal with a broad range of problems. He also points out that senior management has become more aware of alcoholism than of other problems and is, therefore, more willing to support alcoholism programs. He acknowledges, however, that restriction of the program to alcoholism causes supervisors to diagnose the problem employee's condition in order to ensure that he is a suitable candidate for the program.

The broad brush program is considered a viable alternative because management is logically concerned with all employee problems. Such programs are thought to reduce the stigma attached to alcoholism programs and may represent a natural progression in the course of program development. However, Trice notes that broad brush programs are more frequently rejected by unions and are limited by the lack of treatment resources, especially in rural areas, and a lack of insurance coverage to provide for treatment.

Perlis (1977) strongly rejects the broad brush concept. He states "problem identification and referral" based entirely on deteriorating job performance criteria

> . . . may be sold by some eager beaver personnel people and professionals to a few unsuspecting labor officials, but most trade unionists do not buy this approach. . . . To convert what should be a purely alcoholism, referral, and treatment program into a "broad brush troubled employee assistance program" covering every personal, social, economic, and behavioral problem is not only diversionary and unscientific but pie in the sky to boot (p. 73).

The logic underlying the employee assistance approach is summarized by Roman and Trice (1976). The supervisor is given responsibility for identifying the problem drinker on the basis of declining job performance. This approach is considered more effective and more in keeping with the supervisor's role than the earlier attempts to diagnose alcoholic symptoms, However, the new approach results in identification of employees experiencing problems other than alcoholism. These employees are also a legitimate concern to the employer. Consequently, the program must

> . . . accept a broader orientation toward identifying and rehabilitating all troubled people rather than an orientation towards solely rehabilitating the problem drinkers that may be in the work force (p. 483).

Roman and Trice note that the above approach has been officially recommended by the NIAAA. The approach is justified on the basis that a) broad brush programs had been found to be more effective in reaching alcoholic employees than had alcoholism programs, and b) that

> . . . training oriented toward general principles of supervision rather than training oriented toward alcohol problems was more effective in creating readiness to confront a problem employee (p. 484).

Additional arguments, favoring the employee assistance approach, include:

1. they reduce the stigma of alcoholism programs,
2. they reduce the likelihood that the program will be perceived as a form of interference in a particular area of the employee's life, and
3. this enhances the likelihood that the program will be seen as part of the management system rather than as a "prohibitionistic or social welfare effort".

Roman and Trice go on to suggest that the broad brush approach may have been adopted by NIAAA in an attempt to appear innovative and to establish its leadership in the field. This provided a basis for a professional identity among the program consultants. In addition, the broad brush program may have been adopted to

> . . . avoid the encounter with the intense boundaries that sometimes characterize medically based activities, especially when approached by a non-professional or para-professional change agent (p. 485).

They note that the previous populist base for alcoholism programs was "not conducive to identification or affiliation with industrial physicians" (p. 485).

Roman and Trice review the following concerns about the broad brush strategy.

1. The EAP approach may reduce the program's effectiveness in reaching problem drinkers because other problems may take priority and avoidance of the term "alcohol-

ism" may sustain the stigma of this disease. Consequently, the momentum of efforts to reach problem drinkers may be blunted.

2. Program effectiveness may be reduced because confrontation may not prove to be applicable to problems other than alcoholism. However, if this technique is discarded the program may no longer be effective with alcoholics.

3. It may not be legitimate to utilize funding from alcoholism agencies to serve other types of problems. However, if alcoholism is the most frequent problem, other problem employees may simply be considered to receive a side benefit of the program.

4. Inclusion of a wide variety of problems creates a need for professional staff. This may prove to be very costly.

5. Labor organizations tend to resist broad scope assistance programs because of the danger that this will enable management to infringe on individual rights in the interests of productivity.

6. The definition of "problem employees" may be extended to include not only "behavioral-medical problems" but also incompetence or inappropriate placement.

> Apparently the philosophy of the employee assistance approach defines all personal problems that affect performance within a disease framework to the extent that the individual is not responsible for them and should not be penalized for their effects on his work if he undertakes efforts to resolve the problems (p. 487).

CURRENT TRENDS

In spite of the concerns documented by Roman and Trice above, it would appear that the concept of comprehensive employee assistance programming is rapidly gaining ground. Booz *et al.* (1975) state that

> Only 18% of all new occupational programs are for alcohol exclusively; 57% are oriented to the "troubled employee" approach, 25% are combined alcohol and drug abuse programs (p. 7).

However, a spokesman for Canada's Department of Health and Welfare states that "Canada is probably the furthest behind of any industrialized country in the world in providing social work service to employees" (McCallum, 1979, p. B1).

PROGRAM EXAMPLES

The following programs are not broadly representative but provide some illustration of the diversity of current programs.

Illinois Bell Telephone (Asma, 1975)

This rehabilitation program for alcoholic employees was started in 1950. The company has 22,000 employees. In 1962 the present concept of identifying problem employees rather than alcoholics was adopted.

The immediate supervisor identifies employees who are not performing adequately. The employee is informed that this type of job performance cannot be tolerated and a visit to the medical department is suggested. The medical department conducts a health evaluation program which is considered to be a case finder for the alcoholism program. However, Asma notes that "the great majority of the people we see on this type of evaluation have emotional problems" (p. 177). If problem drinking is diagnosed the physician refers the employee to the alcoholic rehabilitation counsellor on staff. He provides counselling and coordination of other treatment services.

The company operates a parallel drug abuse program on a similar basis. Constructive coercion is considered a necessary element in motivating most employees. A program evaluation reveals a relatively high success rate of 72% abstinent or improved. However, there is some indication that a relatively small percentage of alcoholic employees are identified throughout the company.

Kemper Insurance Company (undated)

This program commenced in 1964. It is typical of many current programs in that it is defined as an alcoholism and behavioral problem control program and relies on work performance as a basis for identification but goes on to emphasize alcoholism almost exclusively.

The program is extended to family members of employees and encourages consultation between the supervisor and the alcoholism coordinator or other professional staff. Constructive coercion is the basic motivating technique.

Canadian Utilities Limited (1972)

This is explicitly an employee alcoholism program.

> The companies recognize alcoholism and other drug abuses as treatable health problems covered under regular sickness benefits. Employees affected are expected to seek treatment as they would for any other illness which impairs performance of their work. If the employee fails to accept and respond to treatment, and as a result his work performance deteriorates, the company may terminate his employment (p. 22).

The company recognizes alcoholism and other drug abuses as treatable illnesses and offers to assist employees in securing treatment through the Alberta Alcoholism and Drug Abuse Commission or other facilities. The employee is expected to accept responsibility for seeking assistance, submit to initial assessment and maintain any course of treatment prescribed for him, agrees to the release of confidential information to the company concerning the progress of his treatment and acknowledges that failure to maintain treatment as prescribed will constitute grounds for dismissal.

The foreman or immediate supervisor is expected to identify employees whose drinking habits are repeatedly impairing job performance and advise the employee that failure to accept treatment and improve work performance will result in disciplinary action. If the employee is willing to seek treatment he is referred to a personnel officer who takes the appropriate action.

> If professional assessment and treatment are indicated, the personnel officer will arrange for referral–normally to the Alberta Alcoholism and Drug Abuse Commission (p. 24).

United Auto Workers International Union (Tucker, 1974)

The UAW is a member of the United Labor Committee of Missouri which sponsors a comprehensive alcoholic and "troubled member" assistance program. The project commenced in 1973 and negotiated 38 joint labor-management programs in the first 18 months. The policy recognizes alcoholism and drug abuse as treatable illnesses and offers assistance in obtaining treatment. Supervisors are responsible for implementing the policy on a work performance basis. Constructive confrontation is accepted as a primary tool of the program. Employees are referrred to the troubled employee program by a joint union-management committee.

It is noted that the program calls for

> . . . a sufficiently trained, capable internal "referral-to-treatment" function . . . assistance program staff counsellors will gradually recede from client counselling and referral to treatment in that given work place . . . and an in-plant committee will take up these functions (p. 23).

Kennecott Copper Corporation, Utah (Jones, 1975 and 1977)

Kennecott Copper contracted with Human Affairs Incorporated to construct, staff and administer a troubled employee program called "Insight" for the company.

This has become one of the most distinctive programs in the field. The program is based on a simple concept which is

> . . . To make readily available through company-furnished professional counselling, on a confidential basis, the services of community organizations and other professional people to Kennecott employees and their dependents (Jones, 1975, p. 269).

Program utilization is voluntary, confidential and available seven days a week, twenty-four hours a day. Referrals are accepted from any source and for a wide variety of problems.

Program staff are notified of all disciplinary actions involving an employee. The program offers assistance in each case. Jones (1975) notes that

> Employee morale is greatly boosted when it is realized that the company will take an interest in a man's problem and offer him help rather than an insensitive mandatory stipulation of compliance or else (p. 252).

When an employee contacts Insight, the problem is assessed and a referral is made to a community treatment resource. Jones notes that "Penetration of the employee alcoholic problem alone is vastly superior to any other program of which we are aware" (p. 269).

PROGRAM RESEARCH AND EVALUATION

Research efforts in the field of employee assistance programming have been largely concentrated on evaluation of programs on the basis of various outcome measures. This section reviews research shortcomings and presents a summary of available findings with regard to the need for programs, program outcomes, implementation and utilizaton of programs, and conclusions concerning factors which contribute to program success.

SHORTCOMINGS IN EMPLOYEE ASSISTANCE PROGRAMMING RESEARCH

Many writers have decried the lack of good research data in this area. Edwards (1975) points out that very few programs are evaluated and most evaluations suffer from severe limitations. Roman and Trice (1976), in a discussion of program consultation and treatment, point out that

> . . . Evaluation of these efforts is not yet complete, and is made difficult in traditional goal attainment terms, since no standards exist for the success of either the consultation activities or for programs operating in different types of work organizations (p. 469).

Trice (1977) concludes "The simple truth is . . . good data on any aspect of occupational programs is relatively nonexistent" (p. 2).

Schlenger and Hayward (1975) note that research and evaluation efforts have received an increasing emphasis as programs have become more widespread. However,

> While these efforts have made a significant contribution to knowledge in the field, methodological and definitional problems have often served to limit the generality and in some cases the utility of research findings (p. 1).

They go on to discuss three recurring problems in this area.

1. "The penetration rate is purported to be a measure of the extent to which the program is reaching its target population" (p. 2). This rate is usually expressed as the number of problem drinkers identified and referred to treatment by the program during a given time period, divided by the number of problem drinkers in the organization's work force during that time period. However, the estimate of prevalence of problem drinkers varies widely and the number of employees is affected by complex factors of staff turnover.

2. Program success rates have been defined in a variety of ways. Usually, the criterion of success includes significant job performance improvement or a specified period of abstinence. The writers note that job performance is very difficult to evaluate accurately and abstinence may not be an appropriate criterion of success for a program directed at impaired work performance. Edwards (1975) lists a number of studies which utilize job retention as a criterion of program success. The fallacy of this approach is discussed later. Another problem intimated by Schlenger *et al.* is confirmed by Roman and Trice (1976), i.e., most available research is directed toward alcoholism programs and provides little help in developing comprehensive assistance programs.

3. Schlenger and Hayward note that most studies suffer from serious shortcomings in their experimental design. Many studies fail to include a control group. As a result, any observed changes cannot be definitely attributed to the program. In addition,

> Studies of the effectiveness of occupational programs to date have not been designed such that observed changes could be attributed to one or another of the [program] components (p. 11).

THE NEED FOR PROGRAMS

The need for assistance programs has been demonstrated almost exclusively in terms of the incidence and cost of alcoholism. Very few comparable data are available concerning other behavioral health problems.

Incidence

Follmann (1976) notes that

> Data bearing on the scope of alcoholism are seldom hard, scientific facts but estimates, albeit based on reliable sampling methodology and techniques and having reasonable credibility (p. 18).

He goes on to suggest that these estimates be considered as "usable ball park figures". Follmann provides the following summary of incidence estimates. A nationwide survey by the Social Research Group at George Washington University revealed that 12% of all Americans are heavy drinkers. Jellinek, in 1953, has estimated that the United States had 4,390,000 alcoholics. A statistical estimate by Efron and Keller (1963) indicated the presence of between 4 and 5 million alcoholics, or 4% of the adult population. In 1974, the NIAAA estimated that there were nine million alcoholics in the United States. It is estimated that between 100,000 and 200,000 new cases of alcoholism develop yearly. It is currently estimated that two out of three alcoholics are male. The Department of Health, Education and Welfare has estimated that four to five million alcoholics are employed in American industry. However, the National Council on Alcoholism estimated 6.5 million alcoholic workers in 1971. Von Wiegand (1972) states that the NCA had conducted a study in 1968 which revealed that at least 5.3% of the total labor force has alcoholism. This equals 4 million employed alcoholics. He notes that this figure is a conservative floor and that ". . . a lower national average would be inconceivable on the basis of the data reviewed" (p. 181).

The greatest incidence of alcoholism has been found to occur between the ages of 35 and 55, usually thought to be most productive years of employment. An examination of alcoholic incidence records in five differing work places revealed incidence rates ranging from 4% to 10%, with an average of 7.6%. It is estimated that 5.9% of all federal employees are alcoholic (Follmann, 1976).

Lotterhos (1975) notes that the incidence of alcoholism in the work force is estimated between three and ten percent. The most frequently quoted incidence rates range between six and eight percent. Booz *et al.* (1975) report that "of the 76 million people in the work force, it is estimated that three million to 7.6 million suffer from alcoholism." Roman and Trice (1976) report that

> . . . prevalence rates are typically projected to be within 3–5% of the work force in any organization, with variations depending on the age, sex and ethnic composition of the work force (p. 447).

Schlenger and Hayward (1975) note that

> Estimates of the prevalence of problem drinking among employed persons vary widely (from 4% to as much as 10% depending on the industry). However, many experts accept the National Council on Alcoholism's estimate of a prevalence rate of approximately 3.5% of the nation's work force, or as many as 4,500,000 employed alcoholics (p. 1).

The estimates of the incidence of alcoholism are admittedly imprecise. Unfortunately, the research methodology utilized in arriving at these estimates is rarely reported in the literature and the incidence rates are not linked to a specific definition of alcoholism. Additional shortcomings are evident in the lack of studies describing variations in the incidence of alcoholism among different work places or the distribution of alcoholics among various levels within an organization. Trice and Beyer (1977) suggest that "lower status persons may, in fact, have more drinking problems (C[illegible]lan, 1970) . . ." (page 45). Roman and Trice (1970) discuss a number of work related factors which appear to be related to a higher risk of the development of problem drinking. These factors may be summarized as a) an absence of supervision and b) low visibility of job performance. Various writers have suggested that a high alcoholism rate is associated with a high proportion of male employees, a relatively high average age of employees, a tolerant company attitude and is influenced as well by the ethnic composition of the work force.

Very few studies have documented the incidence of other behavioral health problems in the work place. The NCA (1975) notes that

> Some well established union-management alcoholism programs report that 60% to 80% of cases of persistent job performance problems are directly attributable to alcoholism (p. 1).

However, Wrich (1974) states, "Obviously not all people with job performance problems suffer from alcoholism, but NIAAA estimates are showing that over 50% do" (p. 13). Von Wiegand (1974) in a discussion of "problem employees" identified through poor work performance reports that "At least 50–65% of such employees were in this category primarily because of their drinking problems" (p. 83). Presnall (1976a) reports the following distribution of employee problems in a typical work setting with 70% male employees: alcoholism–35%, other dependencies–10%, emotional problems–35%, miscellaneous problems–20%. It should be noted that the above estimates of the incidence of alcoholism in the work place have been derived from programs which, by definition, are designed to identify alcoholics. Therefore these cannot be considered unbiased estimates. Project HELP, a comprehensive assistance program in several large companies in Ontario, reports that only 25% of its referrals are for alcoholism. The other referrals are for: marital problems–30%, individual problems–14%, parent-child problems–13%, and 18% concerned with housing, finances or health (McCallum, 1979).

Costs

Follmann (1976) reports a series of estimates of the overall cost of employee alcoholism to American society. The NIAAA recently estimated that the cost of alcoholism to the American economy is in excess of $25 billion annually. This figure includes $9 billion in lost production and is therefore the cost to the American employer. The remaining costs include $8 billion in health and medical costs and over $6 billion resulting from motor vehicle accidents. In 1976 the National Council on Alcoholism placed the cost of lost productivity at $12.5 billion annually. Of this, $6 billion was made up of absenteeism, sick leave, wasted time and materials, and accidents. Von Wiegand (1977) calculated the cost to industry at $15 billion annually, on the basis of $3,000 per alcoholic employee.

A variety of studies have provided estimates of the average cost per alcoholic to his employer. Lotterhos (1975) places this figure between $1,500 and $4,000 per year. The following estimates by various employers of the cost per alcoholic employee are presented by Follmann (1976).

Employer	Cost per Alcoholic Employee	Explanation of Calculation
1. United California Bank	$10,000 annually	(Calculated for a 5% alcoholism rate)
2. North American Rockwell	$50,220	(Total cost per alcoholic employee–not annual cost)
3. X Manufacturing Company	over $1,000 annually	
4. U.S. Postal Service	$3,000 annually	
5. Illinois Bell Telephone	$2,700 annually	(in wage replacement alone)
6. U.S. General Accounting Office	$2,455 annually	
7. Scovill Manufacturing	$4,550 annually	(in absenteeism alone)
8. An aerospace industry	$3,800 annually	(in absenteeism and lost production)

(pp. 84 and 85)

The aerospace industry also noted that the cost increased from $842 for an employee addicted less than one year to $6,791 per year for an employee addicted for fifteen years. It should be noted that estimates were made in the early 1970's or before.

Follmann notes that

> The cost of alcoholism to industry has several major components, including lost production, reduced efficiency, absenteeism, lost time on the job, lateness, overtime pay, faulty decision making, on and off the job accidents, theft, impaired morale of fellow workers, friction among workers, impaired consumer and public relations, early retirement, premature disability and death, personnel turnover, the loss of skilled and valued employees, the cost of alcohol control programs, and added costs to insurance programs, including life, health, and disability insurances, workmen's compensation, and public liability and property damage insurances (pp. 80 and 81).

Winslow *et al.* (1966) focused on a systematic means of computing costs to the employer for various factors relating to problem employees. Annual costs of over $1,600 per employee were identified for both a group of suspected problem drinkers and a group who had miscellaneous problems. This was compared to $878 annually for a problem-free group.

Pell and D'Alonzo (1970) found that 55% of a sample of known alcoholics had reasonably good attendance for the year of their study. However, the average number of days of disability for known, uncontrolled alcoholics was 19.4 as compared to 5.8 days for a control group.

Trice (1967) surveyed 750 male members of Alcoholics Anonymous. He concluded that work efficiency declines as a result of alcoholism. Trice also noted that lower status workers had higher absence rates, whereas higher status workers were more likely to come to work and successfully hide their impaired ability to function.

Observer and and Maxwell (1959) had found that alcoholics were absent 2.5 times more often and were three times more costly to their employers in sickness payments than normal employees. Berry and Boland (1977) estimate that alcohol abusing workers in the United States earn almost $10 billion less than if they were not abusers. They point out that this figure is "undoubtedly an understatement of total lost production" (p. 41).

Holliday (1978) suggests that the employee's loss of income must be multiplied by 1.3 to include the loss of fringe benefits and by 1.75 to equal the value of lost productivity. Holliday states that 5–10% of employed Canadians drink excessively and 5–10% have other, non-drug-related problems. He notes that the average amount of absenteeism for all Canadian employees is 12.73 days per year. The average value of a day of productivity is $113.75. On the basis of total absenteeism of 550,195 employees per day in Canada, Holliday calculates a yearly loss of $7 billion in productivity due to absenteeism alone. He goes on to note that 55–95% of all illness is caused by stress and suggests that assistance programs are urgently needed to reduce this loss.

Grady (1977) reports on a group of non-alcoholic employees who had an alcoholic family member. She reports that the sick leave costs for this group were more than ten times as great as those for a carefully matched control group. The majority of this sample group had not been involved in their assistance program.

Characteristics of Problem Employees

The incidence and cost of employee alcoholism has been substantiated by impressive but widely divergent statistics. However, relatively few studies have explored the characteristics of problem employees. A brief survey by Archer (1977) reports the following findings. A number of studies have shown that alcoholics in treatment settings tend to be socially and economically integrated members of society. Trice (1962) summarized the basic data on the behavior of alcoholics that could be substantiated:

> –The alcoholic works regularly while his malady is in its incipient and middle stages.
>
> –Problem drinkers are rather evenly distributed through all occupational groups as well as many types of businesses and industries.
>
> –The middle stage alcoholic appears to be lodged heavily among male employees in the ages from 35 to 50 years.
>
> –Work efficiency declines as alcoholism develops.
>
> –In general, the absenteeism rate for a company's problem drinkers is significantly higher than for nonalcoholics.
> (from Archer, p. 16).

Trice also found that white collar workers tended to go to work when they were intoxicated or hung over but were essentially unproductive whereas lower status workers tended to be absent more frequently. Roman and Trice (1976) present the following types of role structures which are

> . . . posited to involve greater risks for the development of problem drinking . . . 1) absence of clear goals, 2) freedom to set work hours, 3) "field" roles, 4) exploitive relationships, 5) work addiction, 6) occupational obsolescence, 7) job mobility, 8) on-the-job drinking (pp. 457 and 458).

However, Archer (1977) states

> While several suggestions have been made regarding a possible relationship between work role stress factors and alcohol abuse, there is little empirical evidence available either to support or disallow them (p. 19).

It has also been found that problem drinking employees do not show an exceptional number of on-the-job accidents (Roman and Trice, 1976) and problem drinking employees are not characterized by high rates of turnover (Roman and Trice, 1977; Smart, 1974).

An interesting study by Trice (1965) compared alcoholic, psychotic and neurotic employees, who had been identified by a health service, with normal personnel. Over a four-year period the medical department diagnosed .74% of the employees as alcoholic, .83% as neurotic and about .39% as psychotic. All three types of problems were found to be very costly to the employer. However, Trice notes that the alcoholic group were in lower status jobs with less pay, fewer promotions, more dependents, less education, more manual work and requiring more mobility.

The major implication of studies concerning the characteristics of problem employees is that very little is known in this area. There is some indication of a great diversity among problem employees which would surely have important implications for the design of assistance programs.

OUTCOME EVALUATIONS

Evaluations of assistance programs have many shortcomings in design and are difficult to generalize because of the diversity among programs. Edwards (1975) points out that the programs which have been evaluated appear to comprise a highly select group. Therefore, present evaluations probably over-represent the success rate of the majority of programs. Because of the absence of definitive studies, this section focuses primarily on several major reviews of the literature in this area. The major themes of these reviews include success rates and cost savings of various programs.

Edwards (1975) notes that four questions of increasing specificity can be answered by increasingly sophisticated research designs. These question are 1) What happened? 2) How much happened? 3) How much happened compared to doing something else? 4) How much happened compared to doing nothing? (p. 67).

He notes that most evaluations are concerned only with answering the question of "What happened?" Edwards notes further that occupational programs often contain the sources of bias identified by Miller *et al.* (1970) which may invalidate the conclusions of the study. These biases include: different definitions of alcoholism, case selection from special populations, reputation of the treatment program, refusal of referral, rejection of applicants, dropouts, exclusion from the study, living or moving beyond follow-up distance, deaths, refusal to participate in follow-up, and effective testing. Although many of the sources of bias can be controlled, or at least reported, Edwards notes that this is often overlooked in the literature on occupational alcoholism programs.

Edwards also notes Bergin's finding (1971) that psychotherapy programs show success rates ranging from 20% to 90% with an average of 70%. Of the remaining 30%, two-thirds show no change and approximately one-third get worse because of the treatment. Edwards notes that this deterioration effect may well occur in occupational programs although it has not been investigated.

Edwards identified sixteen program evaluations which have some bearing on the questions of appropriateness, adequacy, effectiveness and efficiency. He notes that the NCA estimates that fewer than 300 companies in the United States have operating occupational alcoholism programs. Of these companies, he notes that "fewer than twenty had the courage, dedication and resources to attempt an evaluative effort and publish the results" (p. 82).

> Secondary sources typically cite estimates of program effectiveness from 50% to 80% for employees who accept help from an occupational alcoholism or troubled employee program (p. 83).

Among the programs reviewed by Edwards, the estimates of percentage of employees who had improved in the program ranged from 65% to 87%. Of these estimates, nine were based on job retention, three were based on improved work performance, and three were based on a decrease in drinking. Nine of the companies indicated substantial cost savings to the employer.

An average of 12% of referred employees refused to participate in the program—of the three studies reporting on this. Of those who refused to participate, two studies reported that 35% and 61% retained employment.

A survey of evaluations of alcoholism treatment programs (not occupational programs) revealed a range from 15% to 80% in percentage of successful outcomes. Edwards states that many of these evaluations did not report the percentage or number of cases which improved and points out that appropriateness and adequacy of treatment are almost never discussed in the alcoholism treatment literature.

Schramm and DeFillippi (1975) analyzed the findings of 24 previous studies in order to identify characteristics of successful occupational alcoholism programs. They note that occupational programs typically report recovery rates from 50% to 70% compared to success rates in non-work treatment settings which usually average between 18% to 35%. The authors note that the clientele of occupational programs have a generally good prognosis because they are more socially stable and have a greater stake in their recovery.

Trice and Roman (1972) conclude that company programs have success rates of about 50% compared with 20% for state hospital programs and 10% for efforts directed at "police court inebriates" if success is measured by rehabilitation rather than simply job retention.

Roman and Trice (1976) note that most evaluative efforts have consisted of historical, time sequence studies. They note that Franco (1965) concluded that his company program had rehabilitated about half of those recognized as alcoholics. However, Hilker (1972) reported that 57% of employees involved in a company's alcoholism program had remained abstinent for one year and an additional 15% were performing satisfactorily on the job even though still drinking.

Another reported study compared 24 employees with alcohol or drug-related problems who refused participation in a rehabilitation program, with 117 employees who accepted referral for treatment. The report indicates that

> . . . for both groups there was a very significant drop in wages lost for individuals before program involvement . . . contrasted to . . . after program involvement . . . .
>
> Many of those who experienced the program's intervention might well have improved if merely left alone. Furthermore, it is quite possible for a program to "stack the deck" in its favor by selecting those who give most promise of succeeding (Roman and Trice, p. 508).

Heyman (1976) reports a study in which 10% of referred employees had "chosen not to enter the company program". She notes that these employees tended to be younger and more frequently denied having a problem with alcohol when compared to those who accepted involvement in the program. She also found that

> Employees highly coerced into entering industrial alcoholism programs

> because of affected job performance reported a higher proportion of work improvement than those in treatment for other reasons (p. 900).

However, she had earlier suggested that an occupational program may place undue stress on the employee by stressing functional recovery, i.e., if the employee has not received help for underlying problems he may maintain acceptable work performance after "treatment" at the cost of increased stress to himself (Heyman, 1971). This concern is supported by Moberg *et al.* (1976) who found that individuals referred for treatment by companies using coercion were more often "improved" but not abstinent compared to self-referred individuals.

Sarvis (1976) summarized the cost savings experienced by companies through implementation of assistance programs.

1. The Scovill Manufacturing Company "processed" 180 of its 6,500 employees over a three-year period. They estimated annual savings at $186,550. 78% of referred problem drinkers were considered rehabilitated.

2. The Economics Laboratory reports a rehabilitation success rate of 80%. The company reduced treatment costs 60% by utilizing non-hospital facilities.

3. The de Paul Industrial Alcoholism Project receives referrals from 23 companies. A nine-month follow-up study of treated problem drinkers found 71% significantly improved.

4. The Illinois Bell Telephone Company reports a job rehabilitation rate of 72%. Sickness disability of referred employees was reduced by 46%.

5. The Philadelphia Fire Department reported that sick leave was reduced by 55% and injuries were reduced by 67% among referred problem drinkers.

6. Kennecott Copper Company reported that sickness and accident costs for alcoholics were five times higher than average. However, 12½ months after the program was initiated, hospital, medical and surgical costs had decreased 55.35%.

Sarvis concludes that

> . . . an employer can expect a high rehabilitation success rate for problem drinking employees. In addition, an employer can expect a tremendous decrease in the utilization of health benefits (p. 10).

A final note of caution may be in order concerning misinterpretation of research data or promotional literature. For example, Van Wagner (1978) reports

> The duPont program has, perhaps, the strictest definition of "recovery" among current programs—seven years of continuous sobriety—before a client is considered "recovered". Yet the director of this program, Frank Lawlor, estimates a long-term recovery rate somewhere between 81% and 83% (p. 63).

However, in the study referred to (published in the same journal one year earlier) Lawlor (1977) reported that the study initially included 1200 alcoholics and of these, only 306, or 25.5%, were considered recovered at the time of his report.

> This [recovered] group included only those alcoholics who had maintained total abstinence for the full period of seven years! (p. 27)

IMPLEMENTATION AND UTILIZATION

Many writers contend that employee assistance programs have been demonstrated to be successful on the basis of a number of studies which report a high recovery rate. However, Sherman (1976) argues that the penetration rate is a more important measure of program success. He states, "A lot of talk has been given to reaching the problem population to a greater degree, yet this appears to be stressed more in theory than in practice" (p. 39). He notes that an increase in the number of employees identified and involved in the program would result in significantly increased cost savings, earlier referrals and expansion of the program to include other behavioral/medical problems. He concludes, "I think that while the importance of recovery is apparent, we must continue to emphasize penetration in occupational programs" (p. 40).

Von Wiegand (1972) states:

> I have spoken to dozens of company medical officers and directors of these programs, including duPont and Eastman Kodak. All of their experience reflects the same major problem, which is, their treatment results are excellent, but they are not getting cases. They are all aware that the only cases they are getting are the ones that have progressed to the point where it is no longer possible to ignore them (p. 185).

It seems highly significant that throughout all of the research literature almost no mention is made of the percentage of problem employees who become involved in the program. Edwards (1975) in his review of major evaluation studies was able to derive penetration rates for only two of the sixteen programs examined although some indication of program usage could often be inferred. Consolidated Edison reported that two employees per thousand were referred to the program. An oil refinery in the Caribbean reported a yearly penetration rate of 27% into the problem drinking population. However, large companies such as New York Telephones and American Cyanamid referred 38 and 35 employees annually, respectively. Another company with 10,000 employees referred 49 per year and companies with 6,000 to 8,000 employees referred approximately 100 per year. The New York Transit Authority referred 251 employees per year and the Union Carbide Corporation estimated that 2% of its work force had been involved in the program. The highest penetration rate reported by Edwards appears to have been achieved by the Kennecott Copper Corporation which referred 1,053 employees and 1,180 dependents to the program in a twenty-month period. (It was noted that alcohol abuse accounted for 269 of the 1,053 employee referrals.) The above figures suggest that penetration rates vary widely among programs but tend to be extremely low in comparison to the estimated number of problem employees.

Van Wagner (1978) states:

> We know that some programs are achieving penetration rates (identifying and motivating alcoholics into treatment) running between 2% and 3% of their total employee populations per year.
>
> NCA has suggested that a penetration rate of 1% per year can be considered "adequate" . . . . Many programs are not even approaching this rate (p. 64).

Cutler and Jones (1976) found that older progams made substantially fewer referrals for treatment than did newer programs. They suggest that this trend may lead to the ultimate demise of occupational programs. Of even more immediate concern is the implication that present programs are not succeeding in their primary objective of involving problem employees in treatment.

CRITICAL FACTORS IN PROGRAM SUCCESS

Positive Factors

Very little study has been directed toward the factors which are correlated with program success. Schramm and DeFillippi (1975) suggest that the use of constructive coercion is the most important program element. They assert that various studies have shown that coercion does not have an adverse effect on treatment outcome but motivates the individual to accept treatment earlier. Confrontation by the supervisor is considered important because it emphasizes the employee's responsibility for his own actions and precipitates a crisis which is positive because it occurs before job loss and gives the employee time to respond constructively.

Treatment is viewed as a relatively simple step in the recovery process. Its effectiveness is thought to rely heavily on the initial confrontation and the ongoing rehabilitative influence of the job. The authors note that the clientele of occupational programs have a generally good prognosis because they are more socially stable and have a greater stake in their recovery. Archer (1977) supports the above view and points out that, according to crisis intervention theory, confrontation by the supervisor constitutes a psychological and/or social crisis for the employee, resulting in higher motivation for treatment.

A systems analysis approach is utilized by Moore (1975) in proposing an administrative model for alcoholism programming. Moore believes that motivation and support, rather than coercion, are the primary keys to effective rehabilitation.

Moore's model is designed to meet the NIAAA (1973) standards for comprehensive alcoholism service systems. Although this model is not specifically applied to employee assistance programs, it is useful to compare the EAP concept with Moore's model. The model stipulates five steps. 1) Information and motivational services and liaison. 2) Evaluation, diagnosis and referral. 3) Treatment and rehabilitation. 4) Evaluation of treatment effectiveness. 5) Post-discharge follow-up and research (pp. 54–74). It is evident that most occupational programs are involved almost exclusively with the first step. However, Moore notes that the motivational step is frequently neglected in comprehensive program planning. Thus, the work place has a worthwhile contribution to make to the total service system but most assistance programs do not constitute a total program in themselves.

Bennett (1978) lists the following "success enhancing characteristics" of occupational programs:

1. A written policy.
2. Clear procedures.
3. Top management endorsement.
4. Union executive endorsement.
5. Joint union-management committee.
6. Management and supervisory education.
7. Union executive and steward education.
8. Employee and family education.
9. Good communication at all levels.
10. An active, committed co-ordinator.
11. Informal and/or formal counsellors.
12. Active in-house health services.
13. Active AA involvement.
14. Back-up residential treatment center.
15. Good liaison with community services.
16. Periodic program assessment and update. (p. 6)

Specific Problems

Several writers have identified specific problem areas within occupational programs. Heyman (1971) identifies three serious stress points in the operation of employer-sponsored programs for problem drinkers. The first stress point concerns the supervisor's referral of the worker. A number of questions remain unanswered concerning the best method for handling a referral and the necessary training and motivation of the supervisor.

The second stress point concerns the appropriateness of the referral to be made among the various community facilities available. Heyman recommends that a physician who is an expert in alcoholism should make this decision as

> Programs functioning without this medical expertise would logically deprive the alcoholic patient-to-be of various options and would tend to rely primarily on one or another form of treatment (p. 550).

The third stress point consists of the risk that the employee may not pursue the referral or "may become lost in the maze of the various community agencies because the industry does not assume follow-up responsibility" (p. 551). Heyman stresses that a wide variety of treatment resources must be readily accessible to the alcoholic and his family and notes that at present there is frequently no relationship between industry and a treatment agency. Holliday (1978) points out that

> We will be making better use of the health service available in the community if we bring our employees who are troubled with a stressful situation in contact with a professional counsellor who can direct them to the correct type of help or assistance or treatment they require to remove or to cope with destructive stress (p. 8134).

Heyman concludes,

> Industry, commerce and business have accepted the advantage to themselves in viewing alcoholism as a treatable disease. Social work has an important contribution to make in ensuring that the advantages to the alcoholic worker and to the community from these programs are greatly enlarged (p. 552).

Trice (1977) presents the following list of special problems of industrial programs.

1. In some situations program personnel "bypass the policy and its program and rush a drug abusing employee directly into treatment . . ." (p. 8). Trice views this as "probably the most pernicious problem" and points out that this results in a loss of the motivating power of constructive confrontation and may prematurely label an employee, resulting in a self-fulfilling prophecy.

2. Programs have frequently neglected labor unions. As a result, the motivating

power of the program is reduced and the union's community contacts are not utilized.

3. Programs have neglected female employees who may require a somewhat different approach. Trice and Beyer (1978) state, "Evidence is mounting that drinking patterns of women are actually approaching those of men in American society" (p. 3). The authors note that problem drinking among females has been observed to be increasing for more than twenty years. They quote male/female ratios of problem drinkers ranging from 5:1 in lower status occupational groups to 1:1 in higher status social groups. Concern for female employees is particularly important because "women have, or soon will, reach equal labor market participation with men" (p. 7).

Trice and Beyer go on to suggest that women may be more receptive to help and can be effectively motivated through constructive confrontation because they are equally involved in the job (compared with men) especially at higher levels. However, their drinking appears to be more reactive to life stresses and they are more prone to attempt suicide when placed under stress. Consequently, some modifications in the program may be needed to assist female employees.

4. Inadequate or sporadic erforts at program implementation often result in lack of familiarity with the program by managers and stewards. This is considered one of the biggest reasons for low policy use.

5. The lack of implementation is a result of apathy in top management which is considered another consequence of lack of familiarity with the program.

6. Limited insurance has restricted the availability of many treatment resources.

7. Programs have consistently failed to involve problem employees who have high status in the organization (Trice and Beyer, 1977). The authors suggest the following reasons. a) Problem drinking and other deviant behaviours are assumed to be more prevalent among lower status employees. b) Problem drinking is more visible among lower status employees. c) Greater social distance exists between supervisors and low status workers as compared to the relationship at more senior levels. This produces a willingness to use social sanctions against the employees. d) Supervisors of higher status workers see fewer rewards and more risks for themselves in using the policy.

8. Managers and union officials often express deep concern about assurances of confidentiality in the execution of a program because of the in-

> volvement of numerous persons and the potential for lasting stigma that could result (pp. 9 and 10).

9. Often supervisors are reluctant to use the program because they lack the ability to analyze and confront poor performance. In addition, they may not have occasion to use the program for some period of time and lose their "readiness" to do so.

Holliday (1978) suggests that lack of information is responsible for the low rate of program implementation. He states

> So far it has not been fashionable (to provide confidential assistance programs) for a number of reasons:
>
> 1. How does one identify employees that may have a behavioral/medical problem?
> 2. How does one get the employee to accept help?
> 3. What kind of help do I provide, and where do I get it?
> 4. What does it cost and what are the benefits? (pp. 8131–8132)

Lack of Research

Roman and Trice (1976) state "as researchers, we have a basic concern with the data base upon which occupational alcoholism programs are being developed" (p. 511). They list the following basic "data gaps".

1. Epidemiology of problem drinking in work organizations. The authors note that "sound epidemiological research constitues a major problem for the entire field of alcohol research." They note that the diversity of work organizations greatly restricts generalization from one type of company to another.

2. The consultation process.

> While there is substantial anecdotal evidence on why work organizations do not initiate occupational alcoholism programs, we lack a research understanding of the crucial factors that result in program adoption by an organization (p. 512).

3. The process of identification. Information is needed regarding the events that precede identification, the reaction of supervisors to these events, the resistance of the problem employee to identification and the manner in which the subsequent referral is carried out.

4. Processing through treatment resources. Programs tend to identify "hard core" chronic alcoholics initially and later attempt to reach early stage problems.

> Research on the patterning of these referral processes and the extent to which different treatment modalities are successful in bringing about rehabilitation is badly needed (p. 512).

5. Post-treatment job performance.

> We lack substantive data on the impact on the career of an employee who is identified and referred for help (p. 513).

6. Program diffusion within organizations.

> While most persons working in this area . . . often refer to "programs" in a rather glib fashion; we lack an operational definition of a "program" (p. 513).

The authors suggest that there are obvious differences in the levels of investment and commitment that work organizations make to their programs. The extent to which supervisors are actively involved is also an open question.

7. Program development in smaller organizations. A "considerable proportion" of the work force is employed in small organizations which tend to be less formal and have fewer resources than do large organizations. The authors note that relatively little is known about program implementation in small organizations.

The above reveals a great need for further research into occupational programming. In particular, it is evident that very little is known at present about the factors which are most important in determining the success or failure of employee assistance programs.

EMPLOYEE ASSISTANCE PROGRAMS AND OCCUPATIONAL MENTAL HEALTH

As noted earlier, the literature on employee assistance programming is heavily oriented toward alcoholism. Consequently, very little information is available as a basis for the developent of comprehensive programs. Roman and Trice (1976) point out also that comprehensive employee assistance programs require their own philosophical base.

> Apparently the philosophy of the employee assistance approach defines all personal problems that affect performance within a disease framework to the extent that the individual is not responsible for them and should not be penalized for their effects on his work if he undertakes efforts to resolve the problems. Particularly in light of the open-ended definition of psychiatric problems in contemporary society, clear-cut delineation of the population of "problem employees" eligible for benefits under those programs may indeed to be difficult. This highlights the unclear relationship between these programs and the pre-existing specialty of industrial psychiatry, a relationship that to our knowledge has never been explored (pp. 487 and 488).

The authors also note that broad brush programs have, in some cases, been extended to provide assistance to dependents of the employees and place a strong emphasis on self referrals. They state that

> The crux of the matter is the extent to which the employee assistance approach is used as tool to reach developing alcoholics in the work force in contrast to becoming an end in itself (p. 488).

They suggest that the latter tendency is becoming more pronounced. This has resulted in repeated criticism from those whose commitment is in the alcoholism field including the NCA and leaders in organized labor. They seem to be concerned that the comprehensive approach will result in the neglect of alcoholism. They state that

> The value of occupational alcoholsm concepts may be eclipsed unless the employee assistance strategy is clearly and openly advocated as a means for reaching the neglected population of employed problem drinkers, and is evaluated on that basis (p. 489).

Because employee assistance programs are increasingly becoming involved in the domain of occupational mental health (which evolved from industrial psychiatry) this section provides a brief review of the occupational mental health perspective. In order to present a broadly representative view of the occupational mental health approach, extensive use has been made of a collection of 34 papers and articles edited by Noland (1973). He states

> The purpose of this book is to provide a comprehensive view of what various companies and individuals have done in anticipating, discovering, understanding and dealing effectively with problem employees (p. xi).

HISTORICAL DEVELOPMENT

In a detailed historical review, McLean (1973) refers to occupational mental health as an "emerging art". This designation is intended to reflect the roots that this field has in industrial psychiatry. Throughout its development, occupational mental health has been concerned both with the treatment of mentally ill employees and with an emphasis on preventative services through enhancing the environmental factors which contribute to healthy behavior.

For approximately a century prior to 1870, industry was characterized by exploitation of its workers. The rise of the labor movement brought about increasing emphasis on the wellbeing of the worker. As work came to be viewed as a source of satisfaction, interest in the worker's mental health gradually appeared. By 1915 the first full-time psychiatrist was employed in an American industry. In 1919 Southard investigated emotional problems among workers and found that of 4,000 discharged employees, 62% had been discharged because of social, rather than occupational, incompetence. Southard went on to recommend the development of industrial psychiatry through the employment of psychiatrists on a consultant basis in a preventative rather than curative role.

In 1927 the *American Journal of Psychiatry* commenced its review of industrial psychiatry. The first review noted that the development of industrial psychiatry had been stimulated by the psychometric studies of psychologists in industry, the adjustment problems of men in the armed forces during the first world war, the propaganda efforts of mental hygienists and the introduction of scientific methodology into psychiatry.

In 1927 Mayo commenced his study of working conditions at the Hawthorne plant of the Western Electric Company in Chicago.

> These studies demonstrated the tremendous importance of human interaction as an integral part of the work situation, and that dissatisfactions arising in or out of the plant become entwined, influencing each other and affecting work production (Mclean, p. 112).

Little or no development occurred in this field during the 1930's. However, World War II placed a high demand on industry. During this period psychiatrists and psychologists became very active in developing means of enhancing productivity. Significant on-the-job improvement was obtained through minimal treatment in "emotional first aid stations". However, many industrial mental health programs were discontinued when the war ended.

In 1948 the first fellowship program was begun to train psychiatrists to work in industry. This period also marked increasing interest in specific problems such as alcoholism, accidents, emotional problems of executives, etc.

During the early 1950's, Dershimer expressed concern about the lack of acceptance of psychiatrists in business and industry. He believed this was because

> Psychiatrists have no knowledge of the realities of private enterprise, they belittle the practical knowledge of the field of human relations possessed by industrialists and they resort to name-calling when industry fails to demand their services (McLean, p. 116).

However, Dershimer identified an increasing tendency to treat psychoneurotic employees while they continued at work. Increased concern was expressed for management education and sensitivity training which was offered by the National Training Laboratories.

During the late 1950's several new full-time psychiatric programs were implemented and public awareness began to increase. By 1964 it was estimated that more than 200 psychiatrists and 150 clinical psychologists were active in industry. However, most of these were on a part-time or consulting basis.

Although labor unions have expressed interest in mental health issues and in some cases have included psychiatric services as a part of their comprehensive health program, few mental health programs have been sponsored jointly with management. Unions have traditionally been concerned that mental health programs should not be paternalistic, undermine the grievance procedure or in any way subvert the union movement.

> Where a company has successfully established a program that avoids these pitfalls, the union will often work with it in close cooperation, but formal participation is avoided (McLean, p. 123).

McLean notes that occupational mental health programs are utilizing a variety of techniques. However, there appears to be a widespread reluctance to publish work in these areas. Consequently, most program activities have ". . . to a large extent developed independently as isolated phenomena in different centers" (p. 129). He also notes a lack of coordination between the community mental health centers and occupational mental health programs. He notes that only three states have included occupational mental health in their planning of community mental health centers. This failure is particularly significant when it is considered that community mental health centers represent a counterpart to the comprehensive alcoholism treatment centers which are utilized by industrial alcoholism programs.

There has, however, been an increase in awareness of mental health issues by occupational medicine. It is estimated that one-half of the occupational medicine caseload consists of patients with emotional problems. For the future, McLean recommends a greater emphasis on preventive health programs, research, management education and concern with policies influencing employee mental health.

NEED FOR OCCUPATIONAL MENTAL HEALTH PROGRAMS

Extent of Need

Gordon (1973) estimates that "a psychiatric problem exists in industry which involves at least a quarter of the working force" (p. 158). McMurray (1973) estimated in the early 1960's that seventeen million Americans, 10% of the population, were suffering from some form of mental illness as compared to 3,800,000 who were problem drinkers. He estimates that at least one-fifth of a company's employees are or will be victims to some degree of mental disorder, deterioration, or deficit. He also estimates that at least 80% of the conditions which cause employees to become "problems" are functional disorders including emotional immaturity, neuroses and psychoses. He concludes that mental illness, particularly in industry, constitutes one of society's most costly and universally devastating problems.

Rosen *et al.* (1973) investigated the extent to which physicians in industrial dispensaries detected emotional problems in their patients. Of 3,165 patients, 4.8% were considered to have emotional disorders. The frequency of identified disorders was twice as high for the separated and divorced persons as for the single and married individuals. More than half of the patients had been bothered by their disorder for over five years. 58% were considered to be moderately or severely psychiatrically impaired and 5% showed no functional impairment. 56% had received previous psychiatric care.

In other studies, between 9% and 17% of similar populations were found to have emotional disorders. The physicians provided supportive therapy to 96% of the emotionally disordered patients and medications for 66% but only 12% were given suggestions for environmental changes.

Trice (1965) compared alcoholic, psychotic and neurotic employees, who had been identified by a health service, with normal personnel. Over a four-year period the medical department diagnosed .74% of the employees as alcoholic, .83% as neurotic and about .39% as psychotic. All three types of problems were found to be very costly to the employer. It was concluded that the medical department is not an effective identifier of problem employees.

Conley *et al.* (1973) estimate that mental illness reduced marketable output by $14.3 billion in 1966 in the United States. The total cost to society was estimated at approximately $20 billion. Winslow *et al.* (1966) reported that a group of problem drinkers and a group of employees with miscellaneous other problems represented approximately equal total costs to the company.

Characteristics of Problem Employees

Noland (1973) defines a problem employee as ". . . one who does not conform to the social vocational role expected of him at his place of employment" (p. xi). He goes on to point out several basic implications. It is the organization which sets the standards that define an employee as a problem. These standards are roughly but not exactly equivalent to the standards by which professionals define normality or adjustment. Thus, the problem must be defined in terms of the interaction between the employee and the work environment.

The source of mental health problems at work is also a complex issue. Some employees have psychological problems when they commence work and these may improve or deteriorate. Some employees develop problems after commencing work and these problems may or may not be influenced by the work setting. Some employees perform very well in spite of, or because of, their problems. Some employees with no identifiable psychological problems function poorly because of environmental or situational factors. Noland states

> As long as the employing organization retains troubled employees, it must undertake preventative and remedial action to the extent necessary to maintain company objectives and department efficiency (p. xiii).

McMurray (1973) states that

> Most functional mental illnesses, the neuroses and psychoses, are, in effect, only bad mental habits, the majority of which were formed early in life and are therefore very resistive to change (p. 7).

He describes alcoholics, the mentally ill and others displaying aberrant behavior as "fugitives from reality". He suggests that they represent a very high cost to the employer in terms of high turnover, absenteeism, substandard production, poor morale, poor public relations, labor disputes, and poor decision making.

Gordon (1973) notes that the common characteristic of the mentally ill employee

> . . . is his failure to meet his basic responsibility for living and working productively . . . .
>
> The real cause of the difficulty in the nervous patient is that he is not being required to behave properly and probably never was required to do so . . . (pp. 151, 152).

Kutash notes that industrial psychodiagnosis is a difficult, highly professional technical art and skill. He goes on to state that all of the major psychogenic disorders are intimately related to job adjustment, work motivation and job satisfaction. Frequently, the early symptoms appear in some form on the job. He notes that short-term treatment has proven fully satisfactory in restoring problem employees to acceptable work performance. He concludes,

> Psychologists have learned that satisfactory work experience is often the greatest force in mobilizing emotional energies to meet creative challenges, and that resolving emotional conflicts concerning work and vocation is among the most rewarding methods of healing emotional illness (p. 37).

PROGRAM DESCRIPTION

Most occupational mental health programs emphasize prevention rather than treatment. Thus, they concern themselves with research and policy decisions which concern the development of working conditions which will enhance the health and wellbeing of the work force. Programs designed to provide treatment consist primarily of the provision of psychiatric and medical facilities for employees experiencing emotional distress. There is seldom a clearly defined program involving coordinated action by the manager and the clinician.

Levenson (1973) presents three counselling programs which are intended to represent a broad sample of such counselling practices in industry.

The Western Electric Company implemented a counselling program as a result of the Hawthorne studies. Forty employees were designated as counsellors and received some inservice training. Each counsellor was given responsibility for 300–400 employees. The counsellors were available for confidential interviews in which they maintained a neutral, confidential listener's role. No official records were kept. The counsellor focused almost exclusively on the adjustment of the employee through an increased understanding of the problem.

The Prudential Life Insurance Company established a counselling center staffed by three psychologists and one social worker. The goals of the program were improved morale, greater job satisfaction and increased friendly relations between the company and its employees. The center was responsible to the vice-president in charge of personnel but was separate from personnel administration. It had neither administrative responsibility nor authority. No formal records were kept and no contact was made with anyone else in the company about the client. Counselling was primarily non-directive but included some advice and interpretation. In the first year of operation 331 clients visited the center. In addition, executives frequently requested consultation regarding personnel problems.

The Caterpillar Tractor Company created a mental health section in its medical department. The section is staffed by three industrial psychologists and a clinical psychologist. Local psychiatrists serve as consultants. The section is involved in selection and placement, employee counselling and supervisory development. The counselling service provides minor psychotherapy, consultation with supervisors regarding management of employee problems, provision of psychometric data to company physicians, assistance in arranging transfers, job changes and medical leaves of absence for emotionally distressed individuals, assistance in referral to outside treatment agencies, consultation with physicians and supervisors regarding post-treatment rehabilitation, and the maintenance of case records on all cases.

All interviews are confidential and only work-related information is discussed with supervisors. Employees may seek counselling voluntarily or may be referred by physicians, supervisors or personnel officers. The counsellor has access to all company records concerning the client. With the employee's knowledge and consent, contacts are made with plant and family physicians, social agencies and the counsellee's family if necessary. In one year there were 4,239 consultations with employees or with management about employees.

A study of 500 employees referred to the service revealed that of 130 sufficiently well documented cases, 82% had improved in various degrees and 18% showed no evidence of improvement in the employee's emotional health.

Gordon presents an interesting report on the psychiatric service in the duPont Company. Over a two-year period 7% of the plant personnel were referred for psychiatric consultation. Gordon estimates that there were probably three or four times as many more patients (potentially) as had been seen. The referred patients were fairly representative of the plant population with regard to age, length of service, health, level of responsibility and social and economic status. However, the group was characterized by extensive absenteeism, a higher accident rate, excessive personnel problems, excessive visits to the dispensary and excessive utilization of medical, supervisory and union officials' time. They had a long history of poor productivity and had received extensive assistance from various sources. As noted earlier, Gordon believes that mentally ill employees are characterized by irresponsible behavior which is a result of not being required to behave properly. Gordon states that these patients were not lacking in job security and "Efforts to cure the patient by changes in the environmental conditions only prolonged the disability and set the stage for recurrent illness" (p. 153). He notes that supervisors and some doctors showed a superstitious fear of the emotionally sick employee. This ". . . led to a policy of appeasement and efforts to remove the individual from the stresses and strains of life" (p. 153). Gordon's approach routinely required the emotionally ill employee to return to full regular duty at the same job. Whenever necessary, the supervisor was advised to disregard all future excuses for poor performance. The supervisor was advised to concern himself solely with the man's behavior on the job and to require an adequate standard of work performance. Gordon emphasizes that both the supervisor and the doctor needed to cooperate in confronting the employee with his responsibilities within their respective roles.

Gordon considered cases improved only where definite objective evidence of improved performance was available. Five years after the project was begun, two-thirds of the entire patient group were still actively employed. Approximately half of the entire group was considered to have improved. A distinctly higher rate of improvement was found among those who had accepted therapy.

Gordon concludes that

> Management and supervision can successfully rehabilitate many emotionally sick employees by requiring normal performance. The sickest individuals seen are those who have had the most done for them . . . .
>
> It is possible early to identify the potential problem employee by properly centralizing and correlating pertinent data.

> In the author's opinion, the psychiatrist's chief function is to make a diagnosis of the emotionally sick employee and give medical support to management for what is at present an unpopular course of action (pp. 158, 159).

PROGRAM EVALUATION

Success rate and penetration rates are not frequently reported in occupational mental health literature. There is, however, some evidence that mental illness affects a large proportion of the working population and represents a high cost to the employer. It is also suggested that appropriate intervention may result in significantly improved work performance. However, the percentage of mentally ill employees who are identified and treated appears to be typically very low. The most successful programs appear to be those utilizing the greatest level of cooperation between the medical specialist and management.

SIMILARITIES AND DIFFERENCES

Employee assistance and occupational mental health programs both appear to comprise a wide diversity of specific program types. Both programs appear to define their target population in increasingly similar terms. Both demonstrate a high incidence of problem employees and a resulting high cost to the employer. Both types of programs have demonstrated a potential to treat problem employees successfully but appear to have difficulty in identifying a large proportion of their target population. There is some indication that both programs have been directed primarily at long-term problem employees. Also, both programs stress the importance of confidentiality. Another similarity of both types of programs is their ongoing debate concerning the usefulness of the medical model in relation to problem employees.

In many respects, however, the mental health perspective represents the antithesis of the alcohol-oriented employee assistance point of view. The two types of program appear to engage in virtually no collaboration although they operate in the same environment. Employee assistance programs are considered primarily a management responsibility and emphasize the supervisor's responsibility to identify and motivate problem employees. Mental health programs, on the contrary, appear to emphasize the medical department's responsibility to serve as a treatment resource to employees who may wish to utilize them. A somewhat incongruous corollary exists in the fact that employee assistance programs emphasize treatment and problem resolution whereas mental health programs emphasize prevention. Assistance programs concentrate on the employee's responsibility to perform satisfactorily whereas mental health programs stress the importance of the work environment as a cause of employee problems. Employee assistance programs have been promoted much more vigorously as a result of their heavy reliance on alcoholism treatment organizations. Mental health programs lack a corresponding relationship with community mental health services. Consequently, employee assistance programs rely heavily on external treatment resources whereas mental health programs consist of in-company resources. Employee assistance programs are more concerned with the employee's value to the work place in contrast to the mental health program's concern that the work place may harm the employee. However, union cooperation is more actively solicited by assistance programs than by mental health programs.

It would appear that employee assistance programs and occupational mental health programs could both benefit substantially from a sharing of data, philosophies and resources. Comprehensive assistance programs, in particular, appear to have much in common with occupational mental health. At present, it appears that both programs have failed to capitalize on the potential benefits of effective cooperation between the work place and the treatment community. However, both programs appear to have valuable components of such cooperation and would enhance their effectiveness by pooling these resources.

THE SITUATION IN CANADA

Relatively little is known about the development of occupational programs in Canada. This may well be explained by the fact that such programs were pioneered in the United States and are still relatively new to Canada. In addition, the programs have not received the same powerful sponsorship in Canada as in the United States. Several studies, however, have focused on the Canadian situation and provide a basis for a tentative review of current trends.

CUTLER AND JONES

Cutler and Jones (1976) suggest that occupational alcoholism is a

> . . . movement of dichotomies and a movement of semi-isolates . . . the issues are often discussed with reference to two seemingly mutually ex-

> clusive categories; professional versus non-professional (AA), management versus labor, NIAAA versus NCA, broad brush versus narrow brush, controlled drinking versus abstinence, operational programs versus paper programs, self-referred cases versus job detected cases, and early alcoholics versus late alcoholics (p. 28).

They point out that some program coordinators appear to be isolated and subjected to various conflicting pressures. They conclude that the movement is in some danger of losing its role as a viable force in the work place. If the programs are to remain viable the authors conclude that comprehensive troubled employee programs will have to be developed on an official basis so that supervisors will receive adequate support and supervisors will have to overcome their tendency to identify only the most extreme cases of alcoholism.

CORNEIL

Corneil (1976) presents a summary of an informal survey of individuals involved in occupational programs throughout Canada. He notes that Canadian programs have developed rapidly within the past ten years. Early efforts in this field were centered in Ontario and Alberta. These early programs emphasized identification of alcoholism by emphasis on overt drinking behavior.

Canadian programs have been strongly influenced by developments in the United States. Many Canadian programs were established in branch offices by the parent American company. Corneil notes that the spread of programs across the country has been influenced more by large national corporations than by provincial alcoholism agencies. However, this trend changed in 1965 when a number of provincial agencies were formalized and began employing full-time occupational consultants.

A consequence of the American influence in Canadian programs is a perceived lack of Canadian material and content in this field. A number of individuals expressed concern that the Canadian situation may differ significantly from that in the United States.

Canadian programs most commonly assume that the incidence of alcoholism in the work force is around 5.3% and the cost is approximately 25% of the individual's annual salary. Alcoholism is usually defined as

> . . . drinking that brings about serious problems in physical, mental, family or economic areas for the drinker and the people around the drinker (Corneil, p. 4).

Some concern was expressed that many program staff have "little or no understanding of the theories and concepts that underlie much of their work" (page 4). The concept of constructive coercion is widely used but is often called "progressive discipline". A number of concerns were expressed about this approach. Corneil notes that "broad brush theory was not expressed by many although most felt that this was the direction to pursue" (p. 6).

Strong management involvement was most often considered the critical factor in establishing a policy and a program in an organization. However, management personnel

> . . . were suspicious of the persons selling these programs due to the types of results claimed and the apparent lack of understanding of the concerns of business or personnel management (Corneil, p. 7).

Corneil notes that "almost no active union participation is found in operational aspects of the programs" (page 8). However, labor is being increasingly represented in programs and a few programs have received union ratification.

Program policies appear to be very similar across the country. Unfortunately, many policies are not implemented and remain only as "paper programs". In addition, little attention has been paid to administrative procedures for implementing policy. Many respondents also felt that supervisors receive too little training. Almost no mention was made of the role of shop stewards in the program.

The treatment process was also a subject of some concern because employees, in some instances, were turning up at treatment centers with no idea of why they had been sent. Almost all respondents also identified the lack of treatment facilities as a major problem. It was agreed by most respondents that most referrals are currently in the chronic stage of alcoholism. However, treatment programs and methods also appear inadequate as they have been designed for "chronic skid row types". Some treatment personnel felt that program consultants were leading employers to place high expectations on the treatment agency which could not always be met. Problems were also identified regarding payment for time off work to attend treatment and for "psycho-social-oriented treatment". Corneil also found that "A large number of respondents felt that too much emphasis was being placed on identification and referral and not enough on follow-up" (p. 11).

Corneil found no programs which utilized the penetration rate as a measure of program evaluation. The most common definitions for recovery included abstinence and remaining on the job. Most respondents assumed recovery rates of 60–80%.

> All persons identified the strongest need in the field at present was for good research and evaluation. They felt that this was vital to any future development. Almost all respondents felt that current data were not sufficient and that there would be increasing critical examination of these programs which would require good evidence to support various claims and approaches (p. 12).

Corneil also notes that most respondents did not consider the work place as a causal agent in the problem of alcoholism and few expressed concern about application of the program to women. The majority also noted that the major program emphasis should be on treatment rather than prevention at this point. Concerns were expressed about the difficulties in applying the program to high status employees and the increasing availability of alcohol in and near the work place.

DESJARDINS

Desjardins (1977) reports on a survey of 1,000 organizations across Canada which was designed "to find out about existing policies and programs dealing with alcohol in the work place". Approximately one-third of the organizations responded. Of these, 77% had a policy and 65% had a program. Desjardins notes that the survey included all organizations that were considered likely to have a policy concerning alcohol-related problems. He considers it unlikely that many organzations having policies and/or programs were missed. The responding organizations reported a total of 1,096,733 workers. However, some of these may have been counted more than once.

One-half of the respondents represented industry and approximately one-quarter each came from service organizations and from government. A total of 175 organizations stated that they have a formal program for alcohol-related problems. 57% of the policies were directed at alcoholism problems, 27% were directed at behavioral problems and 14% were directed at discipline problems. Desjardins notes that the tendency toward development of "broad brush" or "employee assistance programs" appears to be increasing. He notes that 85% of the respondents utilized a "constructive coercion" approach.

Identification of problem employees is considered by various organizations to be the responsibility of supervisors–35%, managers–22%, medical department–21% or shop stewards–14%. 42% of the organizations provide treatment through their medical or other social service personnel within the organization. Full-time and part-time staff employed by the organizations consists of medical doctors–37%, nurses–29%, social workers–9%, psychologists–7% and others–19%. The category "others" often included the program coordinator, AA, provincial alcohol commissions or local social services. Where treatment was provided by other agencies, these included the provincial alcohol commission–35%, AA–31%, local social services–16%.

The policy was considered a management initiative by 45% of the responding organizations. 24% stated that the policy was endorsed by the union and 28% stated that it represented a joint labor-management program. Desjardins notes that the average policy in Canada has existed for five years. He concludes that most of the programs were created around 1972. 57% of the organizations stated that they had received assistance from the alcohol commission in establishing their program. Desjardins notes that many respondents appeared unaware of the work being done by others in this field. He concludes,

> Little seemed to be known about recent studies and new trends; the same figures and quotations are used time and again, with little evidence of verification of sources or validity. Better information is sorely needed (p. 20).

YURKIW

Yurkiw (1978) surveyed 264 industries in Calgary, Alberta. His findings are based on the 34 employers who stated that they have a specific employee assistance policy. Yurkiw notes that, of these, only twenty had a program designed to carry out the policy.

Yurkiw notes that few of the industries in Calgary with 100 or more employees have a specific policy to deal with any behavioral health problems. He concludes that "The majority (87%) of those questioned practice an informal and inconsistent approach toward assisting employes with problems" (p. 70). Yurkiw notes that industries with less than 100 employees are even less likely to have a policy. He reports, also, that approximately 75% of the respondents to his initial telephone survey indicated they had specific experiences with employees suffering from alcoholism. "These employees were retained on staff but eventually terminated when the problem became chronic and unmanageable" (p. 71).

Yurkiw found that

> Calgary community resources, with the exception of AADAC (Alberta Alcoholism and Drug Abuse Commission), are seldom consulted by an industry to develop a policy, or to offer some form of social service (p. 73).

He notes that 62% of the policies were endorsed by management only and 26% were endorsed jointly by the management and the union.

All of the policies were found to include alcoholism and drug abuse in their target population. Other problems addressed by the policies included: mental illness–32%, financial difficulties–29%, marital problems–24%, family problems–21%, legal problems–21%. Yurkiw suggests that the trend toward comprehensive programs is still in its early stages.

In 88% of the programs the supervisor was given responsibility for confronting the troubled worker. However, members of the personnel department were mentioned by 32% of the programs and managers were mentioned by 18% in this regard. Union stewards were not considered responsible for confronting troubled workers.

In most cases (71%) the personnel department was designated as the resource through which referrals should be made. The medical department was utilized in making referrals by 47% of the industries and 12% utilized other community agencies. Where treatment services were provided within the company the personnel department was utilized for this purpose by most industries–32% full time and 36% part time. Medical doctors were utilized full time by 15% of the industries and part time by 29%. Company nurses were available full time in 32% of the industries and part time in 3%. No social workers, psychologists or psychiatrists were available within the companies.

Most of the companies expressed a preference for internal treatment resources. Their first choice of a treatment resource consisted of: the medical department–35%, the personnel department–32%, AADAC–6%, Alberta Social Services and Community Health–3%, and AA–3%. Alberta Mental Health Services and hospital outpatient departments were not designated as a first choice by any company and were not used at all by 97% and 91% of the total, respectively. Yurkiw notes that counselling and problem solving by personnel officers appear to be considered treatment functions in many programs. In relation to the low level of utilization of community treatment services, Yurkiw notes that

> In general the findings indicate inadequate coordination, cooperation and communication among community agencies that have the potential resources and skills to assist troubled employees toward better mental health and more efficient functioning (p. 77).

The findings of the studies reviewed above indicate that Canadian programs share many of the characteristics and problems of American programs. However, Canadian programs appear to be at an earlier stage of development, largely due to the limited efforts in the areas of program promotion and research. This, in turn, may be the result of an absence of program sponsorship by powerful organizations and with substantial government funding. It may be concluded, therefore, that Canadian programs are in a good position to avoid the pitfall identified by Roman and Trice (1976) of developing firmly entrenched philosophies and procedures before adequate research data have been generated.

CHAPTER III

RATIONALE FOR STUDY

Serious problems have been identified in the previous chapter concerning the rationale for employee assistance programs. Conflicts exist between various basic concepts of the program. In addition, various components within a given program appear to lack consistency. There is strong evidence to suggest important differences between actual practice and the stated rationale. In addition, programs rely heavily on assumptions which are unsupported by research data, and, in some cases, actually conflict with existing research findings. Finally, many gaps and inconsistencies have been noted in the overall concept of comprehensive employee assistance programming.

NEED FOR A CONSISTENT PROGRAM CONCEPT

Historically, early occupational alcoholism programs consisted of a technique for dealing with alcoholic employees. This technique consisted primarily of the use of construcive coercion and represented a commitment by management to "do something" about this problem. The original technique has been amplified, applied to new target populations in an increasing variety of work settings, directed toward a variety of new objectives and its success has been measured to some degree. However, a factual and theoretical basis for use of this evolving technique has not been consistently defined. The lack of a sound, consistent rationale must be considered a central weakness of employee assistance programs. Several writers have expressed concern for the continued existence of such programs if these basic issues are not resolved (Cutler and Jones, 1976; Roman and Trice, 1976).

Roman and Trice also point out that rational program development is currently distorted by the involvement of organizations with strong vested interests. They stress the need for research-based development. However, the generalization of research findings is severely limited because of the wide variation in program rationale, procedures, resources and contexts. The problem of program inconsistency is, therefore, a research subject of urgent concern.

A second major concern with existing concepts of employee assistance programs relates to the lack of involvement by the work place in developing the rationale for such programs. The supervisor, in particular, has been defined as the key person in program utilization (Trice, 1969; NCA, 1972; Heyman, 1976). However, almost no research is reported in the literature concerning the validity and appropriateness of various assumptions on which the supervisor's effective involvement is predicated. Accordingly, this study has examined the supervisor's perspective in addressing the problem of program inconsistency.

The review of program issues presented in this chapter is based on the assumption that a) the employing organization's point of view must play a central role in program development and b) comprehensive employee assistance programs are the logical outcome of the ongoing development of the original alcoholism program concept. The purpose of this chapter is to review program elements and inconsistencies as a basis for defining specific research questions. Prevailing assumptions and practices are compared to pertinent research findings and program critiques. The review is directed toward delineation of issues in the development of a consistent, integrated program model and an attempt is made to identify common elements as a tentative basis for such a program definition. It should be noted that the focus of the review is on improving the quality of the program rather than on developing an implementation strategy for a new program concept.

PROGRAM RATIONALE

Most writers emphasize the importance of cooperation among the employer, union, treatment agency and the employee. However, each group views the program differently and expects different benefits (Roman and Trice, 1976). The "alcoholism industry" represents society's interest in reducing the prevalence of untreated alcoholism. However, even within this group there is some competition for funding and influence and little concern is expressed for the program's impact on local treatment agencies. The employer's primary interest is considered to be in cost benefits. However, this motive is increasingly being challenged by unions and its importance is questioned by a number of recent writers.

In addition, little is known about the differences in perspective among industry, business, government and other fields of employment. The potential difference in perspective between senior management and the front line supervisor has also not been examined. It is generally assumed that the supervisor is the primary representative of the employer. Labor leaders tend to consider programs as an extension of health benefits and job security. They frequently express concern regarding abuse of programs by the employer and restriction of employee rights.

The above differences among the key partners in the program represent an obvious problem in establishing a consistent program definition. However, it is equally obvious that a successful program would be of greater benefit to each group than are programs which have failed because of lack of cooperation.

In spite of conflict among the above groups, a basic rationale is generally accepted. It is agreed that a) there is a significant incidence of behavioral health problems (or alcoholism) in the work force, b) these problems have a negative effect on attendance and work performance which is costly to the employer, c) these problems can be successfully treated, and d) the employer can motivate the problem employee to accept treatment.

THE NEED FOR PROGRAMS

The need for programs has traditionally been based on the incidence and cost of alcoholism. However, there is evidence to suggest that alcoholism is not the primary problem causing poor work performance. In order to be relevant to the employer's interest in productivity, the program must, therefore, become more comprehensive.

Blair (1978) states

> Throughout North America there is wide recognition of the need for confidential assistance programs which are broad enough to encompass a range of emotional problems. (Quoted from *Mental Health News,* 1977, p. 12.)

It follows that the employer's need for the program relates to the resolution of work performance problems because of their impact on the effectiveness of the whole organization. Because poor performance results from a wide range of behavioral health problems, and because usual management techniques do not provide a mechamism for effective problem resolution in such situations, an assistance program is needed which provides new techniques and expertise in dealing with problem employees in the work place.

PROGRAM GOALS

A variety of program goals have been enunciated by the various interest groups involved in the program. These goals include cost savings, case finding, job security and health benefits, fulfillment of corporate responsbility and providing help for troubled employees. Roman and Trice (1976) point out the important role of the various interest groups as the "constituencies" served by the program and supporting the program. They suggest that many conflicts exist among these groups and the direction of future program development will be greatly affected by the relative influence of each group. They also indicate that is is not likely that management will provide strong support for the diffusion of occupational programs nor that companies will implement effective programs as a means of meeting their social responsibilities. Thus, unions and the "alcoholism industry" may have the greatest influence in future program development.

However, Noland (1973) suggests a viable basis for active management involvement. He states,

> As long as the employing organization retains troubled employees, it must undertake preventative and remedial action to the extent necessary to maintain company objectives and departmental efficiency (p. xiii).

Several other writers have also implied that effective functioning of the employing organization is a valid program goal. Sadler and Horst (1972) note that supervisor training in program techniques resulted in tightening and improving management practices throughout the organization. "The advantage of an employee assistance program is that it helps supervisors be good supervisors and managers be good managers" (Trice, 1977, p. 5). It is interesting to note in this regard that supervisory training in the program has been found to be more effective when it concentrates on good management procedures rather than on understanding alcoholism (Roman and Trice, 1976).

It may be noted that the various program goals listed are not mutually exclusive. Rather, they appear to represent differences in emphasis arising from concern over program shortcomings and weaknesses. It may be that initial agreement should be sought on the more comprehensive goal of providing fair, effective resolution of behavioral health problems which may impair effective functioning of employees and the employing organization.

PROGRAM POLICY

The policy defines the method by which the program attempts to meet its objectives. General agreement has been noted among the policy statements adopted by a wide variety of programs. The major discrepancy appears to be the inconsistency of practice with the stated policy.

The definition of alcoholism as an illness is widely advocated as a means of reducing the stigma of alcoholism and increasing the availability of health benefits. However, most programs deal with alcoholism as deviant behavior and emphasize the alcoholic's responsibility to overcome the problem. This confrontation with responsibility is also widely applied to other behavioral health problems included in the program's scope. Proponents of occupational alcoholism programs argue that comprehensive programs foster the stigma attributed to alcoholism. However, it may also be argued that isolating a specific problem for attention may reinforce the stigma associated with that problem. A major criticism of the medical model is that it tends to absolve the individual of responsibility for his condition.

Roman and Trice (1976) note that early programs relied heavily on coercion instead of treatment to bring about improved work performance. Schramm and DeFillippi (1975) state that constructive coercion is a more important program element than is treatment. This lack of faith in the appropriateness and effectiveness of treatment is reflected in the widespread neglect of coordination between assistance programs and treatment agencies. Consequently, the potential effectiveness of the work place in meeting the program's objectives is severely restricted. Additionally, program policies fail to specify any responsibility on the employer's part for providing a healthful work environment or to participate in an ongoing rehabilitative process with the employee.

PROGRAM SUCCESS

Employee assistance programs are generally considered to be indisputably successful on the basis of a limited number of studies reporting high "success rates". However, the studies are frequently inadequate in their design and most often define success in terms of continued employment. This may not be a valid measure because alcoholics have been found to have a highly stable work history. In addition, it is highly questionable whether treatment outcome is the only, or most important, criterion of success. For example, there is strong evidence to suggest that programs are failing in their attempt to become widely dispersed and are not being successfully implemented in organizations which do adopt them. This, in turn, suggests that the majority of programs have a much lower treatment success rate than those reported in the literature. Another implication is that programs typically fail to reach a great majority of problem employees. It seems unreasonable to expect employing organizations to support programs which have questionable success with a very small percentage of problem employees, especially when some employees may, in fact, be harmed by involvement in the program as Bergin (1971) implies. This possibility has not been adequately studied.

PROGRAM DEFINITION AND COMPOSITION

The following quotations from Roman and Trice (1976) reveal the continuing ambiguity regarding the meaning of employee assistance "program".

> At present, it is impossible to give a single characterization that describes all occupational alcoholism programs (p. 460).
>
> While most persons working in this area, including the present authors, often refer to "programs" in a rather glib fashion, we lack an operational definition of a "program" (p. 513).
>
> . . . it may be appropriate to regard this set of ideology and activities as a federally funded social movement at this point in time (p. 509).

The authors also point out that "distinctively different conceptualizations of the program's role and its beneficiaries" characterize programs located in the personnel department and those located in the medical department. Many writers have differentiated between "paper programs" and operational programs, which have a mechanism for implementing program policy. This section deals with the elements which comprise a program and the dynamics through which a program functions. The program is here conceptualized as *a dynamic interaction of the work place, the treatment community and the employee, which coordinates and maximizes the resources inherent in each for their mutual benefit by enhancing their ability to function effectively. The program's purpose is to resolve behavioral health pro-*

blems which impair the effective functioning of the employee and the employing organization.

PROGRAM ELEMENTS

The Work Place

The program elements include the work place, the treatment community, the employee and a central program resource which coordinates these elements. The work place is generally considered the central program element because it proides the context for the program and serves as the initiator of the program's process. The work place may be considered to be comprised of the employer, the work environment and the union.

The Employer

The literature typically treats the employer as a unitary entity. However, the "employer" frequently consists of a complex organizational structure made up of a variety of roles and functions. Major differences exist among employing organizations which vary in size, location and purpose.

Dixon (1978), in discussing differences between private and public sector management, notes that the public sector is more democratic, therefore, does not stimulate efficiency as the private competitive environment does. He points out that "it is more difficult to discipline public employees than private employees", especially non-unionized ones, although the situation in Canada is much better than in the American public service (p. 22).

The employer is represented by two types of management function. "Line" management is concerned with meeting the organization's central production or service objectives and personnel management is concerned with issues involving the employment contract between the employer and the employee. Also, senior management may have a very different perspective from that of the front line supervisor who is the primary representative of the employer to the employee on a day-to-day basis.

The Work Environment

The work environment is seldom discussed in program literature. However, some concern has been expressed that the work place may contribute to the development of behavioral health problems (Roman and Trice, 1976; Noland, 1973). The work environment has both physical and social aspects. However, the importance of social factors in effective program utilization has received very little attention. Thus, the program is designed on the basis of formal goals and functions in the work place and neglects the influence of personal, informal relationships, attitudes and structures.

The Union

The role of the labor union with regard to assistance programs has gained increasing prominence in recent years. Earlier alcoholism programs were considered to be clearly the employer's responsibility and prerogative. However, in recent years the unions are increasingly demanding that they be included as full partners in "joint" programs. The meaning of "jointness" has been questioned by a number of writers. Sadler and Horst (1972) strongly advocate joint programs. They state that both labor and management have vital roles to play in the program, both should be involved throughout the implementation of the program, the program should be jointly directed and administered, credit for program success should be shared and employees should be informed of the full and active support of both labor and management. However, the writers acknowledge that "It is perhaps inevitable that in a cooperative alcoholism program the investment by management will exceed that by the union" (p. 28).

An unfluential union spokesman (Perlis, 1977) reflects labor's skepticism regarding the program. He notes that management is primarily concerned with the alcoholic as a productive worker whereas labor is concerned with the alcoholic as a fellow-worker with a problem. He suggests that this difference in emphasis is at the heart of many labor-management misunderstandings and disagreements regarding the program.

The major problem in defining joint programs appears to lie in the fact that such programs presume a parallel involvement by labor and management. However, the idea of parallel and equivalent roles is not supported by their broader role definitions in the work place. Labor and management do not, in fact, jointly administer the work place and the personnel policies within it. Consequently, management has a more central obligation and ability to initiate program action. McWilliams (1978) points out that

> Unilateral union programs help many alcoholics, but recovery rates are comparatively low since many of those referred to the program are not motivated to accept the treatment offered (p. 99).

It would appear that the present concept of occupational programming is heavily reliant on the normal management function in the work place. It would seem appropriate, therefore, that the union's role in the program should be based similarly on its traditional role as the employee's advocate, ensuring that adequate benefits are provided and that program provisions are not abused.

Definition of Program Responsibility

The implementation of a program within the work place requires that program responsibilities be defined for the various components of the work place. Senior management and union officials are typically considered responsible for the decision to adopt a program and formally supporting its utilization. The "central" program responsibility for identification, motivation and referral of problem employees is assigned to the immediate supervisor.

An important distinction is made between programs which are located in the personnel department and those located in the medical department of a company (Roman and Trice, 1976). The majority of programs appear to be considered a personnel responsibility. In such programs the medical department is considered a resource to the program rather than as an integral part of the program. The responsibilities of the nurse or physician are seldom clearly stated. However, it is assumed that the medical service will accept referrals from the personnel department, diagnose the problem and direct the employee to a suitable treatment agency. Some writers suggest that the medical staff may play a major role in motivating the employee by informing him of the adverse effects of alcoholism.

A more basic concern regarding involvement of the medical department concerns the appropriateness of medical intervention and the medical model as a primary treatment approach (Roman and Trice, 1976; Blair, 1978). However, the seemingly deliberate circumvention by some programs of medical involvement raises questions about the capability of personnel administrators to accept primary responsibility for providing counselling and making decisions concerning the need for treatment and the selection of a treatment resource. Additional concerns include the appropriateness and capability of the personnel department to address itself to problems in the work environment which may influence employee health. Also, the shop steward's role remains highly ambiguous. He is presumed to represent the official union position as the supervisor is presumed to represent the employer. In both cases this assumption may well be ill founded.

Many programs recognize the need to provide some coordination of these various components within the work place. Some of them have adopted the recommendation to employ a program coordinator to fulfill this function. In most instances, however, the coordinator is simply a personnel officer who has been designated added program responsibilities. Frequently, minimal time and resources are allocated to the coordinator and he becomes simply the company's contact point with community treatment agencies (Trice, 1977). In any event, the coordinator may be subject to conflicting interests expressed by the sponsoring organizations, the employer, union, treatment agencies, supervisor, company health care staff and the employee himself. Blair (1978) states that

> Personnel selection, classification, training, development, evaluation, supervision, labor-management relations, counselling, personnel research, *and* administrative action on behalf of employees at all ranks should be parts of an integrated system (p. 14).

He notes also that such integration cannot be provided by "outsiders who cannot be well informed about the worker's environments".

A very small number of programs appear to have implemented a recommendation made by Trice (1971) and NIAAA (1976) that a diagnostic and referral service be established as a coordinating mechanism between line supervision and the treatment resource. The implications of this innovation are discussed more fully under "program dynamics".

The Treatment Community

The treatment community represents the second major partner in the employee assistance program. However, most programs appear to consider the treatment agency as an isolated resource to the program rather than an integral part of it although a number of writers have emphasized the importance of close cooperation between the work place and the treatment agency. These concerns have centered around the means of making treatment readily accessible and ensuring that an appropriate resource is selected. However, the viewpoint of the treatment agency with an interest in the quality of referrals to it, has not been represented. Roman and Trice (1976) have suggested that treatment agencies could abuse industrial programs because of an interest in increasing the volume of referrals. However, Bannon (1975) states,

> It is already evident that Canada's medical facilities are too understaffed and overburdened to deal with the alcoholic patients referred to them from such conventional sources as private physicians, social workers, and the courts (p. 423).

The lack of consideration of the treatment component appears to be rooted in the historical development of assistance programs. Early programs were limited to alcoholism at a time when this was not considered a disease and when treatment options were severely limited, consisting primarily of AA involvement. The heavy involvement by personnel administrators in the program and the program proponents' jaundiced view of medical intervention have combined to foster a decidedly "non-professional" philosophy in the program, policy statements notwithstanding. A number of implications have been noted in the literature that the "offer of treatment" may frequently operate as a "threat to impose treatment". For example, Perlis (1977) emphasizes the pragmatic need for the alcoholic to simply stop drinking and notes that "nobody knows precisely the causes and cures of alcoholism" (page 71). Roman and Trice (1976) state

> To a considerable extent, early occupational programs emphasized the potential impact of constructive confrontation as a crisis-precipitating event that could potentially bring about an alteration of behavior in and of itself. The minimizing of the need for treatment was viewed as a particularly meritorious feature of this program approach . . . (p. 499).

They go on to note that this emphasis has been replaced by the medical model as a means of minimizing supervisory responsibility and assuring that assistance is provided by competent individuals. However, they criticize the current approach because "the 'rush to treatment' emphasis appears in some instances to have even supplanted the confrontation itself" (p. 499). Consequently, the organization is required to "develop a new organizational component" instead of simply altering its procedures. In addition, these authors suggest that the use of treatment services should be minimized because of

> . . . the potential impact of labelling that inevitably occurs when persons are processed through treatment facilities. These labels not only create risks of subsequent stigmatization on the job and in the com-

> munity, but can also act to alter the self-concepts of individuals, which in turn may impact on their behavior (p. 500).

The major representative of the treatment community in program development is the "alcoholism industry". However, these organizations do not represent the local treatment facility nor treatment agencies which are not alcohol-oriented. Roman and Trice (1976) note that occupational programs must compete for funding with treatment organizations. In addition, their orientation is toward program promotion rather than availability and quality of treatment resources. It has also been noted that community mental health services have expressed almost no interest in industrial behavioral health and have had no involvement in occupational program development.

The Employee

The third major partner in the assistance program is the individual problem employee. However, the need for programs is based largely on the problem employee's reluctance to initiate corrective action on his own behalf. Consequently, the individual employee has been a passive partner in terms of program development and has participated only in reaction to the initiative provided by the work place. The union is usually assumed to be the primary representative of the employee's interests. However, the union representative may frequently find himself in conflict with the program which is also defined as serving the employer's interest. In addition, the commitment of labor to the seniority principle implies that junior members will not be supported in a conflict of interest with a senior union member.

A number of programs have included the employee's family within the scope of the program. However, little progress has been made toward the effective utilization of the problem employee's family as a program resource. The program also fails to serve as a "consumer advocate" in obtaining a high quality of treatment services for the employee.

PROGRAM DYNAMICS

Basic Assumptions

The concept of employee assistance programming is based on the assumption that a) behavioral health is related to work performance, b) behavioral health problems can be resolved through effective treatment, and c) the work place can motivate problem employees to accept treatment. However, many writers appear to question these assumptions and, consequently, the validity of the program concept itself.

If it is true that the work place can motivate problem employees through application of its legitimate performance standards and disciplinary authority, there is no need for the program to redefine a disciplinary procedure designed to provide motivation. Consequently, the program should respect the integrity of the work place and simply capitalize on the motivational potentialities in it. Because this motivational potential is a management prerogative, it follows that management is responsible for initiating program action. This allows the union to also participate in its normal role as the guardian of employee rights and benefits.

If treatment is considered effective in resolving behavioral health problems, and good behavioral health is associated with effective functioning on the job and elsewhere, the primary goal of all program components should be to involve the problem employee in treatment. However, there is increasing recognition that behavioral health problems involve the individual's relationship with the physical and social environment and do not simply constitute an internal defect. Therefore, effective treatment must also concern itself with these relationships. This requires full cooperation of the work place, the treatment agency and the employee. Thus, a comprehensive psycho-social model of treatment is needed as opposed to the exclusively medical model.

In order to achieve the needed cooperation, the responsibilities of all program participants must be clearly defined. These responsibilities must be fully consistent with each participant's normal role. Accordingly, the employer should accept responsibility for confronting problem employees with the existence and normal consequences of impaired performance. This confrontation must occur in the context of a positive offer of assistance. The union is responsible for protecting the employee's rights and obtaining needed benefits within the employment contract. In addition, the union has a responsibility to refrain from subverting the employer's exercise of his legitimate requirements and authority. The employee is responsible for maintaining a level of health which is required to perform effectively on the job. If he fails to do so, he becomes responsible to accept assistance in resolving the health problem. The treatment agency's responsibilities include the provision of sufficient quantity and effective quality of treamtent services in cooperation with the work place.

Need for Coordinating Mechanism

The above concept of the assistance program provides for the involvement of each participant in the context of their legitimate, ongoing roles and functions. The central program dynamic, therefore, consists of the synergistic coordination and utilization of the resources contributed by each. This requires the establishment of a mechanism recommended by Trice (1971) and NIAAA (1976) which is frequently designated as a "diagnostic and referral" service or an "employee counselling unit". The primary function of this unit is to coordinate program elements. The unit may serve, firstly, to coordinate the various components of the work place. This ensures that senior management, the immediate supervisor, the personnel department, the union representative and various employee benefit programs are working in harmony. Secondly, coordination is frequently required among various treatment agencies. It is reasonable to assume that many problem employees are experiencing multiple problems and require a coordinated treatment approach which may involve the family doctor, specialized assessment services, specialized treatment, counselling, residential treatment and family services in some combination. The third and fourth areas requiring coordination involve the relationship between the treatment agency and the work place. The unit should represent the treatment community in the work place as the channel through which referrals are made. This greatly simplifies the referral process for the supervisor and ensures that a comprehensive range of treatment resources are made available to the employee. In addition, the unit should represent the work place to the treatment agency in order to ensure a high quality of referral information and an understanding on the part of the treatment agency of the expectations and characteristics of the work place.

In addition to coordination, the unit needs to provide a variety of preventative services. These include education of supervisors with regard to program utilization, assistance to the employer in identifying environmental factors which impair the employee's ability to function effectively and provision of assistance to self-referred employees before work performance has deteriorated.

A direct treatment function is also required. This would provide "in-house" treatment to employees whose problems relate so closely to factors in the work place that an outside treatment resource would be unable to deal with the problem effectively. In some cases treatment would be provided by the unit because of inaccessibility of community resources. An important part of the treatment function would consist of crisis intervention counselling as a necessary adjunct to the confrontation process by the supervisor which is defined as the precipitation of a crisis in the employee.

Need for Professionalism

The high degree of responsibility and complexity of the above functions require that the unit operate on a highly professional basis. Professional objectivity must be ensured by staffing the unit with qualified professionals and ensuring that the unit has the freedom to function independently. The unit should be committed to the resolution of behavioral health problems and should not become involved in disputes concerning the employment contract. These provisions would ensure that the unit would be a viable resource to all levels of employees.

The unit must also maintain a high level of professional ethics and confidentiality. These need to be safeguarded by a commitment from the employer to respect the unit's clinical confidentiality, formal procedures to ensure that confidentiality is maintained and by the staff's commitment to its professional code of ethics.

Professional competence must also be assured in order to provide a high quality of service. The staff must be well trained as clinicians and utilize a comprehensive, psycho-social treatment approach in order to effectively integrate all of the treatment resources available in the work place and the community.

The diagnostic, counselling and referral service described above is an essential program component as it relates to the employer, the treatment community and the employee. The existence of such a service as part of the work place enables the employer to make a concrete offer of help. This legitimizes his motivational efforts because he is no longer simply obligating the employee to seek assistance. Also, the employer's helping role is extended from the provision of financial medical benefits to a personal offer of treatment through the unit.

The treatment community gains, from the assistance unit, a point of contact with the work place from which it has been traditionally isolated. Consequently, the quality of referrals is enhanced through provision of adequate referral information, assurance of appropriateness of the referral and through increased client motivation as a result of pre-referral counselling by the unit. In addition, the unit provides to the treatment agency a mechanism through which the work place may be utilized as a treatment resource. The work place may assist significantly in treatment through monitoring post-treatment performance, assisting in providing suitable job placement, reducing environmental stress and assuring the treatment agency of cooperation in achieving treatment goals.

In relation to the employee, the assistance unit also performs a valuable function in assuring that the treatment agency will be appropriate to his needs and effective in providing assistance. The unit also serves to ensure that restoration of the employee's behavioral health is maintained as the primary goal, especially where this may conflict with management's interest in productivity or the union's interest in protecting financial benefits. The coordinating function of the unit also serves to protect the employee from a self-defeating tendency to invest only token involvement in treatment as a means of meeting the employer's requirements rather than resolving his own behavioral health problem.

It must be acknowledged that the dynamic coordination of program components outlined above could be achieved only in the context of a commitment by the various program components to re-examine the basic philosophy of the program and to resolve numerous real difficulties in achieving such coordinated action. However, because coordination represents the central element of the program, this must be achieved if the program is to succeed. The implications of a coordinated program approach are examined more closely in the following section dealing with the sequential process of the program.

PROGRAM PROCESS

The employee assistance program involves a series of steps which include: identification of problem employees, motivation, referral, treatment, and re-integration into the work place. The literature emphasizes the identification and motivation steps as a result of the program's current preoccupation with the role of the work place. This section provides a review of the basic issues in each step as part of a total process.

IDENTIFICATION OF PROBLEM EMPLOYEES

The identification process is based on a number of assumptions about the type of problems toward which the program should be directed, the way in which these problems should be viewed and the relationship between such problems and the work place. The traditional view has been that alcoholism is prevalent in the work place and represents a significant cost to the employer. It is a disease which can be successfully treated through abstinence. Consequently, the alcoholic is obligated to overcome this problem as a means of restoring his work performance to an acceptable level in exchange for the privilege of continued employment.

TYPE OF PROBLEMS INCLUDED

A basic controversy exists between those who believe that occupational programs should limit their attention to alcoholism and those who favor application of the program to a wide variety of behavioral health problems. This controversy is confounded by those who suggest that the program should deal with all behavioral health problems but for the express purpose of dealing more effectively with alcoholism.

It would appear that exclusive concern with alcoholism is an artifact of the program's historical development and a current reflection of the biased interests of the "alcoholism industry". There is strong evidence to suggest that alcoholism is not the primary problem causing poor work performance and is not more costly than are other types of problems. Therefore, neither the employer's nor the employee's interests are best served by limiting the program to alcoholism. In addition, a number of programs have demonstrated comparatively good success in dealing with other types of problems, suggesting that the program's techniques are more broadly applicable. It is noted that there is general agreement that identification of problem employees should be based on work performance criteria. Consequently, the inclusion of a wide range of behavioral health problems is a logical result of the program's methodology. The implications of a comprehensive program for alcoholic employees have, however, not been fully explored. The NCA (1973) argues that comprehensive programs tend to maintain the stigma of alcoholism by failing to stipulate this as their primary concern and are subject to manipulation by alcoholic employees and abuse by employers. However, NIAAA (1976) states that comprehensive programs reduce the stigma of alcoholism and contribute to an increased rate of identification of problem drinkers.

Another basic difference of opinion is emerging with regard to the program's concern with health issues as opposed to situational problems of employees. Weissman (1976) notes that some programs include a variety of situational and social difficulties in their area of concern. However, such programs require significantly different techniques and resources. The definition of behavioral health problems included in this study takes account of situational influences on health but inclusion of situational problems per se would clearly involve a major definition of the assistance program concept. Physical health problems represent another potentially contentious issue in the definition of the program's scope. Physical illness and disability often has a behavioral component, however, which may serve as the criterion for the individual's inclusion in the assistance program.

USE OF THE DISEASE MODEL

The second major consideration in the identification process concerns the way in which the defined problems are viewed. A major controversy concerns the definition of alcoholism as a disease. Meaningful discussion of this issue is difficult because of definitional problems and concern over practical implications of various viewpoints. Robinson (1972) notes that "no area of medicine is so bedeviled by semantic confusion as is the field of alcoholism" (page 1041, quoted from Davies, D. L., 1969). Lotterhos (1975) notes that

> The simple statement that alcoholism is a disease is misleading since it is too narrow and conceals the fact that a step in public policy is being recommended, not a scientific discovery announced (p. 18).

Most writers in the field of occupational alcoholism staunchly maintain that alcoholism is a disease and stress the advantages of this view in obtaining health care benefits and reducing stigma. However, they go on to recommend program techniques which are based on the individual's responsibility for his behavior and define the illness in terms of social irresponsibility. Archer (1977) notes that the disease/medical model of alcoholism has been criticized for its lack of explanatory power, its insistance that abstinence is synonymous with rehabilitation and recovery, its failure to take proper account of socio-cultural factors and its implications for social policy. She notes that the socio-cultural viewpoint is essentially "less concerned with the etiological forces that produce problem drinking . . . than with the social responses to problem drinking, which either encourage or dissuade it" (page 12). She suggests that early programs relied heavily on the disease model and

> . . . encouraged companies to view the problem drinker as a sick individual who could be rehabilitated with appropriate medical attention and the psychological and social support provided by membership in AA. . . . constructive confrontation . . . parallels the AA notion of the necessity of "hitting bottom" before motivation to stop drinking occurs (p. 12).

Archer suggests that NIAAA's approach relies more heavily on the socio-cultural model and sees programs as "having more properly a personnel than a medical function, consistent with its greater emphasis on psychological and social factors in problem drinking" (page 12).

Davies (1974) states

> The concept of alcoholism as a "disease" has outlived its usefulness. By employing it, alcoholics are missed, and those who are recognized . . . are well advanced in the condition (p. 210).

O'Bryant *et al.* (1973) point out that

> Alcoholism is a condition whose course, whether progressive or arrested, does not depend solely upon what happens inside the victim of the disease, but depends largely upon the personal and social surroundings in which he lives (p. 27).

The rationale summarized above implies a serious discrepancy between the stated acceptance of the disease model of alcoholism and the practical procedures of occupational programs. Clearly, a more comprehensive formulation of the problem is needed to encompass the realities of the employee problems encountered in the work place. Numerous hyphenated formulations have been proffered including socio-cultural, medical-behavioral, psycho-social, and socio-medical concepts. Davies (1974) concludes

> If we were to drop the disease concept, (and) regard alcoholism as a medical-social problem . . . sufferers would be recognized more often, and very much earlier; more diverse agencies would be used to help in what is a medical-social problem, and there would be many goals of treatment other than total abstinence (p. 211).

Although the above discussion has centered on alcoholism, a remarkable similarity of concerns and conclusions is noted in relation to mental health problems. Noland (1973) defines the problem employee in terms of his failure to conform to the social vocational role which the work place expects of him. He suggests that the standards set by the employer are roughly equivalent to the standards by which professionals define normality or adjustment. McMurray (1973) describes alcoholics, the mentally ill and others displaying aberrant behavior as "fugitives from reality". Gordon (1973) believes that mentally ill employees are characterized by irresponsible behavior which is a result of not being required to behave properly. Therefore, "management and supervision can successfully rehabilitate many emotionally sick employees by requiring normal performance" (p. 158). W. R. N. Blair, author of a major report which has been adopted as the basis for mental health services in Alberta, states that ". . . mental problems are usually social-psychological in nature" (page 3). He recommends "that we concentrate on non-hospital and, to a large extent, non-medical forms of early intervention and modification of unrewarding behaviors . . . (page 3).

The emerging view of problem employees in the work place appears to consist of an emphasis on the employee's responsibility for maintaining adequate performance and a concomitant responsibility for overcoming personal problems which disrupt his ability to function effectively on the job. "Treatment" is not imposed on the individual but must be actively utilized by him. Thus, the work place has an important role in confronting the employee with the need to accept treatment and assisting him in utilizing a wide range of resources which may enable him to restore his level of functioning. This concept highlights the importance of coordination between the work place and the treatment resource in a combined therapeutic or rehabilitative effort.

PERFORMANCE-BASED IDENTIFICATION

A third fundamental assumption of the identification process concerns the relationship between behavioral health and work performance. A number of studies during the 1960's demonstrated that alcoholic employees were characterized by a wide variety of work performance problems (Trice and Roman, 1972; Von Wiegand, 1974). It appears that these findings led to the conclusion that poor work performance is a reliable indicator of alcoholism. This led to the adoption of work performance criteria as the basis for identifying alcoholic employees. However, subsequent experience has demonstrated that a variety of other behavioral health problems accounts for perhaps an even greater percentage of poor performance. The additional possibility that some poor work performance may not result from the employee's personal or health problems has not been adequately explored. It seems probable, for example, that many work performance problems result from inadequate working conditions, poor morale, lack of incentive, inadequate supervision, inappropriate job placement, lack of training, or a variety of situational difficulties.

The simplistic concept of work performance problems as indicators of underlying behavioral health problems, or specifically of alcoholism, serves as a basis for the heavy emphasis on coercive motivation. The employee is held responsible for meeting his obligations within the employment contract and is, therefore, required to overcome any impediments to good work performance.

Roman and Trice (1976) point out that successful identification of problem employees on the basis of impaired work performance rests on the assumption that the work place has clearly defined standards of performance which are maintained by a high quality of supervision. However, these prerequisites appear to be considered lacking in most work places as many writers suggest that the program is responsible for implementing a motivational system in the work place. This contradicts the basic tenet that the organization's standards and authority serve as a resource to be utilized by the program.

This dilemma may be resolved by conceptualizing the problem in a different way. It may be that the work place is unable to deal with problem employees effectively because it lacks the expertise and mechanisms required to resolve performance problems which result from underlying behavioral health difficulties. Consequently, implementation of an assistance program provides the resources needed by management in order to function effectively within its normal role definition.

A number of shortcomings have been documented in the ability of current programs to identify problem employees. The percentage of problem employees reached by the program appears typically to be very low. Female employees and senior employees are notably under-represented. Traditional programs also fail to capitalize on the employee's own potential for identifying his problems or to identify employees known to have problems but maintaining satisfactory performance. It may be suggested, therefore, that an adequate identification process requires a voluntary self-referral mechanism as well as a means for differentiating between employees who *have* a problem and employees who simply *are* a problem to the employer.

Adoption of work performance as the criterion for identification has been based on the contention that this procedure would result in much earlier identification, especially of alcoholics. Numerous writers have suggested that early signs of poor performance may be much more difficult to perceive at the time and may provide an inadequate basis for program action. Roman and Trice (1976) note that

> If loss of control over drinking occurred very early in the job-life cycle when commitment and psychic investment were low, then it is less likely that a confrontation would have motivating meaning (p. 453).

It is noted that early performance problems may reflect a transient situational difficulty which is not a proper target of program action and are, in any event, not subject to dismissal or other significant sanctions which are considered necessary to motivate the employee. It is not surprising, therefore, that many writers have reported that the program appears to concern itself primarily with chronic, late stage alcoholics (Cutler and Jones, 1976; Corneil, 1976; Yurkiw, 1978). Edwards (1975) found that alcoholic employees had been severely abusing alcohol for four to ten years before being identified. Towle (1974) found that identification and referral of employed alcoholics through occupational alcoholism programs occurred at an average of 12.2 years after onset of heavy drinking. This is compared to 15.8 years in a program serving public inebriates. The above findings are particularly significant in view of the common assumption that early identification is positively correlated with treatment success.

THE SUPERVISOR'S ROLE

As noted above, the supervisor is generally considered to be the key person in program utilization. Roman and Trice (1976) go on to state that "supervisory identification (is) the pivotal point in program functioning . . ." (p. 496). Von Wiegand (1974) suggests that the identification of problem employees is less a question of awareness than a question of whether the supervisor feels it is necessary or appropriate to involve the employee in the formal program process. Consequently, responsibility for the successful functioning of the entire program is seen to rest on the supervisor's judgement.

Most programs assume that the supervisor's role is not altered by the program. Lotterhos states "The supervisor is asked to simply monitor job performance which has always been a significant portion of his job" (page 30). Pierce *et al.* (1977) state

> In implementing an occupation(al) program, your duties as a supervisor are essentially unchanged . . . you are not being asked to become a diagnostician nor a psychologist. You are only being asked to perform in a professional supervisory capacity . . . as a supervisor, your only concern should be your employee's job performance (p. 2).

However, Roman and Trice (1976) note that the quality of supervision and the existence of clear-cut standards for work performance are crucial ingredients in successful identification. They note that a number of problems are associated with these factors. They point out that effective monitoring of work performance is difficult in many complex types of work and the supervisor has only limited authority over the employee. They conclude that

> Supervision often has available only generalized, subjective criteria of performance . . . in short, performance appraisal is a human process that contains the error, biases and stereotyping present in any decision-making that people make about other people . . . . Impaired performance is what supervision defines it to be, and what they believe to be sustainable with their own supervision and staff personnel (pp. 497 and 498).

These authors also suggest that the identification process is hindered by a general tendency in social behavior.

> The basic tendency is to "reclassify" or normalize the observed deviant behavior through temporarily broadening the guidelines for acceptable behavior rather than following the idealized sequence of recognizing it as abnormal, labelling it and attempting to intervene (p. 449).

The authors conclude that counter-pressures are needed to overcome the supervisor's propensity to tolerate deviant behavior.

Trice (1971) stated that the supervisor has a "readiness to act" in dealing with alcoholic employees. However, he vacillates between helping the worker manage the problem and reporting him for disciplinary action. Trice suggests that the existence of an assistance program resolves the supervisor's dilemma. It would appear, however, that the supervisor faces even greater dilemmas within the program. Dismissal is becoming a less available option in dealing with problem employees. Therefore, the supervisor may risk ongoing conflict with the employee by identifying him as a problem. The supervisor also risks his own credibility, the employee's welfare and the employer's interests, in identifying the problem employee (Doran, 1975; Trice, 1965; Moberg, 1974). The timing of his decision is also a complex judgement. The concept of early identification has been called into question because it is difficult and may not prove effective (Whyte, 1977; Bissell *et al.*, 1973). In addition, many problems, including alcoholism, are considered to resolve themselves if left untreated (Drew, 1968).

The supervisor's reluctance to identify problem employees may also result from his awareness of the limited program resources provided by the employer. The program's capacity to deal with only a limited number of referrals conveys to the supervisor a clear message of the limited expectations the employer has for program utilization.

Several writers have questioned whether the supervisor should have sole responsibility for identifying problem employees (Guida, 1976; Heyman, 1976). Some programs have demonstrated that identification can be carried out by: the personnel department, senior managers, the health service or the employee himself. One of the programs most successful in identifying a large number of problem employees is the Insight program described by Jones (1975 and 1977). This program makes identification and referral an automatic part of the disciplinary process and utilizes the employee's family in this role as well. By utilizing a number of identifiers, the program effectively reduces the possibility of "cover up" by a single individual.

A greater emphasis on the senior manager's role in identifying problem employees would assist the supervisor by providing increased support and a more objective resource in making this judgement. In addition, this would allow the supervisor to utilize his informal role as the employee's advocate without being obliged to hide the problem.

The Insight program also promotes increased identification by emphasizing the provision of professional consultation to the supervisor. This provides him with much-needed support and information. In addition, it enables the supervisor to discuss his own feelings within the context of management strategy. Without such consultation, the supervisor must assume on the basis of poor work performance that referral for treatment is appropriate.

MOTIVATION

The motivational technique of constructive coercion, or confrontation, constitutes the basic element in most employee assistance programs. This technique is a legacy of the earliest occupational alcoholism programs. Although a number of variations of the technique are utilized, the basic procedure is widely accepted as the most important contribution of the work place to the fight against alcoholism, in particular. This sections deals with the rationale, dynamics and ethics of constructive coercion.

RATIONALE FOR CONSTRUCTIVE COERCION

The rationale for using constructive coercion is based almost entirely on experience with alcoholism and is based on the idea that alcoholism reduces work performance and thus breaches the employment contract. This gives the employer the right to threaten the employee with dismissal if he fails to accept treatment and restores his work performance to an acceptable level. Because alcoholism is characterized by denial, the employer's confrontation is needed and is helpful because it occurs before the alcoholic employee actually loses his job. Keefe (1973), himself a recovered alcoholic, states,

> . . . the employee will rarely accept treatment unless the consequences of not accepting creates the intolerable alternative. . . . You can't tell him, nor show him, nor ask him. You've got to kick him. You've got to boot the alcoholic; you've got to confront him with a positive assertion that he has a problem. Try the KITA treatment—a "kick in the ass" (p. 17).

Constructive coercion is considered a necessary means of motivating the alcoholic employee to accept treatment. However, some writers suggest that this procedure is effective in bringing about abstinence by itself. Thus, the process has been termed "firing therapy".

Constructive coercion is also thought to be helpful in bringing about early referral for treatment without decreasing the effectiveness of treatment for the coerced employee. However, some writers have expressed doubt as to whether coercion is appropriate in early referral and whether coerced employees benefit from treatment as much as voluntary referrals do (Heyman, 1976; Moberg, 1974, Towle, 1974; Bissell *et al.*, 1973; Whyte, 1977). A number of concerns have also been expressed about the application of this technique to employees with problems other than alcoholism. However, these concerns are based on the presumption that the supervisor has diagnosed the alcoholic before using the technique. Performance-based identification implies that the same technique would be applied to all problem employees and would, therefore, inevitably be applied to some who are not alcoholic.

DYNAMICS OF MOTIVATION

The use of constructive coercion requires a strong exercise of authority by the supervisor. However, the work place has become much less authoritarian in the past thirty years and dismissal is much less available as an option to the supervisor. Schollaert (1977) states,

> It is not clear whether termination accounts for a larger fraction of worker separations among deviant drinkers than among other workers, primarily because this is a fairly rare event in employment relations (p. 179).

The emphasis on coercive motivation has a number of potentially adverse effects. Motivation is reduced to a single event rather than an ongoing process which continues throughout the treatment stage and beyond. This method also assumes that problem employees will not be self motivated, that other sources of motivation are not applicable and that motivation can occur effectively in a confrontation setting.

The definition of constructive coercion as an integral part of the assistance program appears to have resulted in a great deal of suspicion of the program among labor leaders in spite of formal statements endorsing the value of the technique. It would seem more appropriate to define the coercive aspect as a normal part of the employment contract, emphasizing the provision of treatment as the central program function. In this connection it should also be noted that coercion is, by definition, a somewhat mechanistic process. It must be remembered that the point of the exercise is to bring the employee to a recognition of the reality of his situation and to make a commitment to change. Very little mention is made in the literature of less drastic means of motivation such as placing the employee on probationary status, providing frequent and objective feedback on his performance, or utilizing peer pressure through an educational program. Some writers have suggested that the existence of a program may have a positive effect on the drinking habits of many employees who do not come to the program's attention.

Ravin (1975) emphasizes that it is the provision of treatment which makes coercion constructive and it is the blend of coercion with the offer of treatment which makes the program effective. Thus, the integration of coercive and constructive elements is more important than the relative merit of either element. Two major program proponents (Trice, 1969 and NIAAA, 1976) stipulate that effective provision of treatment requires the establishment of a specific service within the program which provides diagnosis, counselling and referral.

Finlay (1975) emphasizes that motivation needs to be ongoing and can play an important role in treatment outcome.

> There is consistent and converging data from alcoholism treatment research which supports the viability and virtual necessity of sustained external pressure in order to render a problem drinker accessible to professional helping efforts.

He points out that such pressure produces a crisis

> . . . which is potentially creative if a person in such a state is sustained and assisted in his efforts to find new, more constructive ways of dealing with life (p. 14).

ETHICS

Dunne (1977) states,

> The use of constructive coercion . . . does place a serious responsibility on agencies, first to provide the best medical care available when indicated and then to monitor the entire program of recovery . . . (p. 107).

It would logically follow, therefore, that the employer has a similar ethical responsibility to make treatment effectively available. Coercion should be applied only toward the objective of accepting treatment rather than as a sanction against poor performance. Foster (1970) suggests that supervisors also have an ethical responsibility to confront problem employees. He states,

> To ignore the early signs of alcoholism intentionally as a well meaning, tolerant gesture is as damaging to the alcoholic as if the same type of response were to be made to the early signs of cancer . . . misguided and well meaning tolerance and ambivalence by care givers represent a distinct failure in the delivery of their services, and is indefensible morally and legally (p. 32).

Kellerman (1975) describes alcoholism as a three-act play. The employer or supervisor is defined as the victim who is responsible for compensating for the alcoholic's poor performance.

> . . . without repeated protection and covering up by the victim, the alcoholic would have to give up his drinking or give up his job. The victim's role is to enable the alcoholic to continue drinking in an irresponsible way and to keep his job at the same time . . . there is almost no chance that the alcoholic will stop drinking as long as other people . . . [remove] all the painful consequences of drinking.

THE REFERRAL PROCESS

REFERRAL AS A COORDINATING FUNCTION

The referral of the problem employee to treatment has received relatively little attention in the literature. However, the referral process is critical to success of the program because of its central role in coordinating program components. A number of implications have already been discussed under "program dynamics".

Historically, it appears that the importance of treatment has been frequently negated. Consequently, referral consisted of obligating the employee to seek help, advising him of the availability of resources such as AA or simply motivating him to improve his behavior to avoid the threat of professional intervention. Roman and Trice (1976) point out that emphasis on treatment implies that the organization must establish a new organizational component to provide diagnostic and referral services. They express concern that the "treatment industry" may maximize the need for service in order to meet its own goals and that the treatment process may result in labelling, and therefore stigmatizing the employee. It is feared that such labelling may foster "sick" behavior in the employee.

This somewhat jaundiced view of treatment appears to be a result of the heavy involvement of lay people in program development and the failure of the "medical model" in treating behavioral health problems—especially alcoholism. In addition, Roman and Trice (1976) point out that no "constituency" has emerged to promote the involvement of psycho-social treatment resources in the program.

NEED FOR COORDINATION

The traditional program view has implied that treatment is essentially a community responsibility, separate from the work place. This view implies that the supervisor must require the employee to obtain treatment rather than offer treatment services to him (Swafford, 1975; Steinhauer, 1976; Brooks, 1976). Treatment is viewed as an isolated component which is effective by itself and is something done to the individual. Work performance is emphasized as the criterion of success. A more realistic view holds that the coordination between treatment and work place is essential to treatment success (Trice, 1965; Sommer, 1969; Jones, 1975; Brubaker, 1977; Soren and Hewson, 1974). This approach implies that utilization of treatment is an employee responsibility but that the offer of treatment is a major component of the employer's responsibility. The criteria of success include the employee's restored health and wellbeing, in addition to improved work performance.

A number of difficulties are being identified in the referral process which were previously not considered a program concern. "Unfortunately, a careful, rational matching of type of employee and treatment facility does not occur very often" (Trice, 1977, p. 112). Trice goes on to state,

> Future programming will have to find ways to interface with treatment facilities so that appropriate referrals can be made . . . the realities of occupational status differences will have to be faced in making compatible referrals. Moreover, the liaison mechanisms between company, unions and treatment facility will have to be made more explicit (pp. 24 and 25).

Heyman (1971) suggests that the referral process may break down due to the supervisor's inability to refer effectively, the lack of suitable resources or the employee's failure to follow through because of the complexity of service delivery systems and the lack of follow-up by the employer. She also suggests that the employee and the employer may have significantly different treatment goals and these should not be concerned only with adequate work performance.

A number of writers have pointed out the lack of adequate and readily accessible treatment resources in most communities. The importance of the referral function, therefore, includes the responsibility for efficient utilization of existing resources and a contribution to the development of new and existing resources toward an increased capacity to meet the needs identified by occupational programs.

THE REFERRAL MECHANISM

There appears to be increasing agreement that employee assistance programs require a formal diagnostic and referral unit as the coordinating mechanism between the work place and treatment community. However the debate concerning professional versus lay staffing reflects the conflict and ambiguity which characterizes the program concept. Early alcoholism programs constituted a layman's approach to the practical problems posed by alcoholics in the work place. However, increasing sophistication of treatment methods, concern for earlier diagnosis of the problem and increasing emphasis on employee rights have resulted in a need for more professional involvement. Inclusion of the total range of behavioral health problems in the program's scope clearly magnifies this need to the point where highly skilled and closely coordinated professional involvement must be considered essential. (This contrasts with the view of the coordinator as a "change agent".)

Trice (1971) emphasizes that the relationship between the supervisor and the treatment agency must be coordinated, either by the medical department or the personnel department.

> Whatever the choice, one point is clear, namely that coordination between line supervision and treatment must be firmly lodged in some well established unit. This unit will receive referral cases from immediate supervision, decide on treatment type and routing, and tell the immediate boss the prognosis. It will process the treatment, whether it be in company or outside, and report to the immediate supervisor when he could expect improvement and how much (p. 25).

NIAAA (1976) recommends the establishment of a similar unit which is called an "employee counselling service" or "employee assistance service".

> The purpose of this management service or control system is to ascertain what is troubling the employee to the detriment of his work performance, and, having done so, to put the employee on a course of action designed to deal with his problem or problems . . . . The staff of such an employee counselling service is not oriented toward therapy. They may be considered as evaluators, guidance counsellors or motivational interviewers whose primary concern is linkage of the troubled person with those community (or, rarely, in-house) services best suited to meet his perceived needs (pp. 8 and 9).

Trice (1973) points out that such a unit is particularly important in a comprehensive program. "Broad brush fits nicely where a company is staffed with something roughly called 'employee counselling services' and has social workers, clinical psychologists etc. available" (page 88).

Wrich (1974) states that one of the essential ingredients for a successful employee assistance program is a

> . . . professionally competent diagnostic component to which troubled employees can be referred and which is capable of diagnosing a variety of problems as to cause, evaluating them, and referring the troubled person to the proper modality of care (p. 16).

However, he goes on to note that the use of alcoholism counsellors to fulfill the function of the diagnostic and referral component has been identified as a problem. He points out that a situation may develop ". . . where management has espoused an employee assistance program, but has set up the apparatus for an alcoholism program" (page 17). However, Wrich maintains that the diagnosis and referral of troubled employees is an identification process rather than a counselling function. In this regard, his concern seems to be that counselling will be equated with alcoholism treatment. Consequently, Wrich designates the unit as a "diagnostic and referral intake resource" and suggests that a wide variety of professional or lay persons could be utilized in staffing the service.

The increasing recognition of the importance of the referral process and the need for a diagnostic and referral service is encouraging. However, a number of studies suggest that few programs have implemented such a unit and, of those who have, many are inadequately designed, funded, mandated or staffed [Trice, 1977(d); Trice and Beyer, 1977; Trice, Beyer and Hunt, 1978]. The diagnostic and referral service clearly needs to be accepted as an essential program component, not viewed as an optional frill.

TREATMENT

Schlenger and Hayward (1975) state that the interface between occupational programs and treatment services is generally assumed to be a simple mater but that the needed coordination is often lacking. The importance of a coordinated approach is demonstrated by Finlay (1978) who reports that modification of the problem drinker's behavior is associated·with: involvement in a social system, experiencing a state of crisis, pressure from significant others in the drinker's role network, the *maintenance* of crisis-level anxiety, expectancy that some solution can be found to his difficulties, treatment personnel who view alcoholism as a problem in interaction rather than a diseased state (p. 273). Thus, the work place can contribute significantly to treatment effectiveness.

TREATMENT AND THE WORK PLACE

An important factor which has been neglected by most programs is the potential role of the work place in enhancing treatment effectiveness. Heyman (1976) suggests that ". . . the ambivalent attitude of supervisors toward referral was associated with the poor therapeutic response of alcoholics when referred for treatment . . ." (p. 900). Sommer (1969) notes that the work place can enhance treatment effectiveness because it provides ongoing motivation and acts as a therapeutic resource. Jones (1975) notes that linkages between program elements are crucial to success in treatment but are difficult to maintain. Bissell *et al.* (1973) note that constructive coercion often results in superficial and temporary levels of motivation which require further development in the course of treatment. The importance of work-related information in the clinical diagnosis of the alcoholic is emphasized by Brubaker (1977). Soren and Hewson (1974) recommend ongoing group therapy in the work place as a means of maintaining gains in treatment. Thus, the work place has been recognized as an important component in diagnosis, motivation, treatment utilization and effectiveness, and is considered a potential partner in the actual provision of treatment.

The role of the treatment agency has also been narrowly defined by most programs. The employer typically is led to expect that "treatment" will transform an unproductive worker into a productive one. However, little mention has been made of the treatment agency's role in providing useful feedback to the supervisor or in helping to correct deficiencies in the work environment which may contribute to the development of behavioral health problems. Thus, the supervisor may not know whether a tolerant or a "hard line" approach will be most helpful to a problem employee or whether certain elements in the work place are exacerbating the problem.

In many instances, the work place and the treatment agency may need to cooperate in determining if treatment is required, whether treatment intervention should be directed toward the employee, his family or the work environment, or to what extent the employee should be held accountable for performance problems.

TREATMENT REQUIREMENTS

The view of behavioral health problems and of the treatment community in the literature appears to have been greatly oversimplified. It is generally assumed that the employee has a single, clearly definable problem which requires a single, readily available resource. Consequently, treatment is simplistically endorsed as a "magic formula" or it is cynically rejected.

In order to fulfill its responsibilities in the program, the treatment community needs to meet several criteria. Treatment must, first of all, be readily available. However, as Bannon (1975) and others have pointed out, there is frequently a shortage of treatment facilities. Secondly, treatment must be readily accessible. Unfortunately, many agencies have long waiting lists, complicated admission procedures and low visibility. In addition, treatment resources are often remote from the work place. Heyman (1971) points out that the complexity of the treatment community may create a problem, particularly in relation to somewhat unmotivated problem employees. It is ironic that the very abundance of treatment agencies tends to render them less accessible. It is noted that the *AID* (Advice, Information and Direction) *Directory* in Edmonton lists approximately 850 publicly-funded health and social service agencies.

In order to be effective, treatment must also be appropriate to the individual. This involves both a careful selection of appropriate resources and the development of resources designed for a specific population. A number of writers have noted the problems encountered by alcoholic senior executives, for example, who find themselves in group treatment with "skid row" alcoholics in programs primarily designed for the latter group.

Because of the multiplicity, specialization and diversity of treatment agencies, the coordination of various treatment components must be considered a critical factor in treatment success. The fact that such coordination is difficult for treatment professionals to achieve only highlights the difficulties of the troubled employee in obtaining comprehensive treatment.

Treatment must also be available, financially, to the employee. In Canada, this problem is less critical than in the United States because of government-sponsored health care insurance. However, the provision of psycho-social forms of treatment, a primary requirement of the program (Blair, 1978), is not covered by the health care insurance plan and is frequently not covered adequately by private insurance plans. This represents a serious shortcoming in treatment availability.

The quality of treatment service is also known to vary among agencies and within agencies. Consequently, it is difficult for the employer to fulfill his responsibility to offer effective treatment to the problem employee.

The above complexities and shortcomings of the treatment community suggest the need for two approaches to the issue of effective treatment provision. The immediate approach should be to establish a diagnostic, counselling and referral unit as described under "Program Dynamics". The long-term approach should include a concerted effort on the part of the employer and program staff to assist in the development of a more adequate system for delivery of behavioral health care services.

TREATMENT SUCCESS CRITERIA

Treatment success in employee assistance programs has traditionally been defined in terms of job retention and, to some extent, abstinence from alcohol and improved work performance (Edwards, 1975). However, job retention has been seriously questioned as a valid indicator of treatment success. Controversy also surrounds the question of whether treatment goals should be defined by the employer or the employee and whether the goal is improved health or increased production. These conflicts seem to reveal a lack of faith in the basic program rationale. If it is true that behavioral health problems result in impaired work performance, it follows that improved health will tend to result in improved performance. It is important, therefore, to establish improved behavioral health as the primary goal. Holliday (1978) notes that "... Good work performance is the bedrock upon which a successful business is built. Good health is the foundation of good work performance" (p. 8135).

In some cases the employing organization must be prepared to sacrifice short-term benefits for the sake of the overall goal. For example, a valuable employee who is experiencing stress-related problems may decide, as a result of treatment, to leave his employer for a less stressful job. It may be suggested, however, that unless the employer has a primary commitment to the well-being of the employee, the assistance program will be neither ethical nor effective in the long term.

Sherman (1976) points out that a variety of treatment outcomes may be expected. He notes that improved health may not result in improved performance whereas improved performance may not reflect improved health. It has also been noted that the health problems of older employees may not be amenable to treatment but that the employer has a certain obligation to such employees. This suggests the need for consideration of expanded employee benefits, rehabilitative programs, vocational and retirement counselling, as well as increased attention to appropriate job placement and provision of a healthful working environment.

It may also be useful to differentiate between treatment success and program success. For example, a problem employee who chooses to reject treatment and is unable to improve his performance by himself, after a clear confrontation and positive offer of assistance, may be consequently dismissed. However, this seems a fair and useful outcome of the program process and may be seen as a successful resolution of the employing organization's problem. Several writers have also implied that the existence of an effective program may have positive benefits beyond the rehabilitation of identified problem employees. It is suggested that some employees will seek treatment on their own in order to avoid having treatment initiated by the employer and potential problem employees will tend to refrain from seeking employment with a company which has a mechanism for identifying and resolving such problems. The importance of social sanctions in limiting abuse of alcohol and other drugs (Trice and Beyer, 1977) suggests the possibility, also, that the existence of an effective program may be instrumental in establishing group norms within the organization which will serve to limit substance abuse throughout the work force.

RE-INTEGRATION INTO THE WORK PLACE

This review has noted a theme of oversimplification in each step of the program's process. Identification, motivation, referral and treatment are typically described on the basis of an all-or-nothing principle. An employee's performance is either adequate or he is subject to dismissal; he either gets help or he doesn't; treatment either solves his work performance problem or it fails. Consequently, the employee's return to work after treatment is considered a simple matter. The employee either performs well with no further problems or he is dismissed. A number of writers, however, suggest that the employee who has undergone treatment should receive some sort of special consideration.

THE RETURNING EMPLOYEE

Although the treatment process may not actually require that the employee be absent from work, there is general consensus that the employee should be accorded special status during the treatment period. However, there is considerable confusion about the employee's status following treatment. Obviously, some employees will have permanent residual deficits and some will require an extended period of time after returning to work before they are fully rehabilitated. Regardless of the treatment outcome, the employee's acceptance of treatment places him in a different position from the pre-treatment phase. He can no longer be seen as a poor worker who is being irresponsible in neglecting to get help. Consequently, he is likely to have either a more or a less favorable status. If the problem has not been resolved, the employee may be almost guaranteed job security out of compassion or because the supervisor finds it easier and safer to "cover up" for the employee rather than confront the issue again. Alternatively, whether the employee improves or not, he may become the victim of the stigma of being labelled with alcoholism, mental illness or poor performance.

Trice (1978) notes that supervisors of highly skilled, sensitive or professional employees "feel that it is difficult to put full trust and faith in a treated subordinate . . . ." when they return to work (p. 3). It must be concluded, therefore, that acceptance of treatment, whether it is successful or not, represents a serious risk to the employee and may create conflict and confusion for the supervisor. Unless these problems can be resolved, they will remain as important factors in the failure of both parties to utilize the program.

RESPONSIBILITY OF THE WORK PLACE

The supervisor is typically instructed to refrain from diagnosing or counselling problem employees. However, it would seem more difficult to adhere to a strictly formal supervisory role with an employee who has demonstrated cooperation, responsibility and good faith in accepting treatment. The employee who has accepted treatment has defined himself as being in need of help. Because of the value of his job in providing status, stability, structure, salary and enhancing self worth, there is an implied obligation on the part of the supervisor to continue providing these benefits as long as the employee is making an effort to resolve his problems. This, however, involves the supervisor in a subjective evaluation of the employee's motivation and response to ongoing treatment and rehabilitation. Therefore, the supervisor becomes an important treatment resource in early identification of signs of relapse. This may place some pressure on him to look for symptoms of the illness rather than simply monitoring job performance. The supervisor must also make decisions about the amount of support and tolerance he should extend to the employee. This decision cannot be made entirely on the basis of his formal concern with work performance. Thus, the fact that the work place constitutes an important resource to the treatment agency in the employee's rehabilitation process, results in potential confusion regarding the employer's responsibility toward the employee. An additional factor involves the possible involvement of formal resources in the work place, such as the medical department, and informal resources, such as employee AA groups.

Again, it is noted that coordination between the treatment agency and the work place is critical to the success of the program. The supervisor requires a source of consultation from the treatment community so that he can contribute to the ultimate treatment goals without losing sight of his clear mandate as a supervisor in a place of work.

THE SUPERVISOR'S PERSPECTIVE

Most writers agree that the supervisor is the key individual in program utilization. "The work world contains one of the most important, emotionally charged relationships in practically everyone's life—the man-boss relationship. Here is an agent almost without peer for identifying, defining and applying a policy of 'constructive coercion' to alcoholism" (Trice, 1971, p. 8). Trice [1977(d)] states that "policy execution . . . depends largely upon the action of immediate supervisors" (p. 2). He notes that supervisors will 1) detect deteriorating performance, 2) motivate employees and 3) inform the employee of resources in the plant and in the community.

THE SUPERVISOR'S ROLE

In spite of the heavy emphasis on the supervisor's responsibility for making the program work, there has been very little investigation of the supervisor's perspective. Many writers suggest that the supervisor's program responsibilities add nothing to his usual role. Assistance programs typically assume that the supervisor is the primary representative of the employer, identifies fully with the employer and acts on the basis of complete loyalty to him. An implicit assumption may be that the work place consists of an employer-employee dichotomy. Roman and Trice (1976) have, however, pointed out that the supervisor must exercise a great deal of judgement. Trice (1978) found convincing evidence that younger and less experienced supervisors were relatively poor at implementing the policy. This implies that certain factors are important in determining the supervisor's ability to utilize the program.

It is generally assumed that training is an important factor in preparing supervisors to fulfill their program responsibilities. However, Trice [1977(d)] states that ". . . Practically nothing is known about training for persons who specialize in job-based policies/programs or who should use them, such as line supervisors and shop stewards" (p. 22). One study suggested that ". . . training must be heavily oriented to the nature and make-up of the work organization, and less so to the unique aspects of alcoholism and drug abuse per se" (p. 23).

THE SUPERVISOR'S PROGRAM RESPONSIBILITIES

The supervisor is considered responsible for identifying problem employees, motivating them to accept treatment and referring them to a suitable treatment agency. Sadler and Horst (1972) state that "management must back the first line supervisor as the key person since he . . . can most easily pinpoint the people who need help" (p. 26). It has been pointed out, however, that the identification process requires clear performance standards, good judgement, consistent performance evaluation, documentation and interpretation of the significance of declining performance. However, it is expected the supervisor will limit himself to concern with work performance and refrain from diagnosis or counselling. A number of writers have suggested, also, that identification is not so much a question of the supervisor's perceptiveness as it is a matter of deciding to involve the employee in a formal program process. The decision to do so may involve some risk for the supervisor. This would suggest that the supervisor requires adequate support and resources in carrying out this function rather than being isolated as being primarily responsible for the program.

Motivation of the problem employee to accept treatment is usually assumed to consist of constructive coercion. NCA (1972) states, "The key to the successful motivation of an employee with alcoholism to accept treatment lies in the supervisor's use of his authority in a fair and constructive manner" (p. 6).

Referral to treatment is also considered a supervisory responsibility. It is noted, however, that the supervisor's attitudes may be affected by the availability, appropriateness and effectiveness of the community's treatment resources. It has been suggested that treatment resources need to be provided within the employing organization if treatment is to be effectively coordinated with the work place.

PROGRAM IMPLICATIONS FOR THE SUPERVISOR

Trice (1971) emphasized that the program should be designed primarily to benefit the supervisor. However, most programs place heavy obligations on the supervisor rather than serving as a resource to him. As a result, the supervisor may find himself in a conflict of roles, performing functions which are not consistent with each other and attempting to fulfill heavy responsibilities without the necessary resources. Cutler and Jones (1976) suggest that supervisors frequently receive less than adequate support.

Daghestani *et al.* (1976) conducted a study concerning the supervisor's role in relation to the problem drinking employee. The study obtained views of supervisors and problem employees. The authors note that "work supervisors inevitably play a pivotal, often crucial, role in the disturbed social and psychological homeostasis of an employee who 'abuses' alcohol. The constantly changing interplay of multiple other factors in the alcoholic's life requires both expertise and flexibility by the supervisor" (p. 88). They conclude that the supervisor's anxiety can be reduced through understanding of his own role. They stress the importance of written documentation of unacceptable work performance and note that "the success of the supervisor to initiate and reinforce the treatment process depends primarily on close cooperation between the supervisor and the medical department" (p. 90). Finally, they stress the importance of active participation by the supervisor in the follow-up stage of treatment.

Various writers have noted that supervisors frequently fail to meet all of the expectations placed on them by the program. This had led to a variety of explanations and prescriptions for correcting the problem. Phillips and Older (1977) suggest "supervisors develop a range of strong feelings similar in nature to those of alcoholic people and their spouses. These strong feelings prevent supervisors from dealing with alcoholic employees in objective, constructive ways. To overcome these barriers, supervisors require specialized counselling" (page 30). The authors suggest that the program coordinator or the occupational counsellor should be available to provide such counselling.

This view of the supervisor is gaining increasing support. Hague (1978) advocates the concept of the "troubled supervisor" who is experiencing problems because of his "troubled employee" (pers. comm.). He notes that such supervisors frequently require counselling.

A more "hard line" approach is taken by Brooks (1976) who states,

> The most effective form of motivation in getting a supervisor to implement an employee alcoholism program by making referrals in the prescribed manner, is essentially the same motivation used to get the alcoholic employee to get help–the desire of the supervisor to keep his job!
>
> . . . supervisors may–or may not–put what they have learned into

> practise. They will do so when, and if, it suits their convenience.
>
> The supervisors will *always* do what *their* supervisors tell them to do. That's human nature—they want to keep their jobs (p. 23).

Dunkin (1978) states that "Most employee alcoholism programs are failing to achieve their maximum potential in terms of early identification of alcoholics and effective motivation for them to accept help, because the line management allows the supervisors to exercise the option of whether or not they will refer any employee to the program" (pers. comm.).

The frustration reflected in the above comments seems to arise from the writers' assumption that the supervisor should act strictly within his formal role. However, it may also be that the supervisor is frustrated by the program's neglect of his personal feelings and beliefs as they affect his relationship with his employees. It is generally accepted that much supervision occurs at an informal level. Thus, the program may be considered to have failed to take account of the personal, interpersonal and social dynamics of the work place. The program relies heavily on the supervisor's authoritarian role. However, the supervisor may not feel rewarded for utilizing the program, may be concerned that poor performance reflects poor supervision on his part and may have serious concerns about the effectiveness of treatment. It has been noted that supervisory experience and clarification of the union's role both enhance program utilization. This may suggest that supervisors perceive the program as threatening and ambiguous. There is also some indication that supervisors have more personal concern for problem employees than has been previously assumed. Daghestani *et al.* (1976) found that supervisors attributed alcohol abuse to personal conflict nine times as often as the alcoholic employee did. They also found that supervisors identified alcoholic employees on the basis of symptoms in addition to the prescribed work performance criteria. They report that recognition of alcohol problems was due to:

absenteeism and lateness	36.9%
lower quality of work	19.1%
avoiding supervisor or coworkers	10.3%
shakiness of hands	8.8%
red or bleary eyes	8.4%
more irritable	7.8%
hangovers on the job	4.4%
attitude change toward coworkers	3.1%
accidents on the job	1.3%
	100%

THE SUPERVISOR'S VIEW OF THE PROGRAM

A number of facets of the employee assistance program concept and current practice have been reviewed in this chapter. It is evident that the problems and shortcomings of current programs require urgent attention. One of the most basic and pervasive problems has been identified as the lack of "fit" between the program and the realities of the work place. Because of the supervisor's central role in the program, as the program "implementer" and the employer's representative, the supervisor's opinions and attitudes must be considered of prime importance. Further, because the supervisor is involved at the practical, "front line" level, he must be considered an excellent potential resource in identifying practical problems and potential resolutions. For this reason, this study was directed toward the description of the supervisor's view of the program. The study is concerned with the entire concept of employee assistance programming, rather than simply effective utilization of the supervisor in the program.

Because of the diversity of program concepts noted above, a tabular comparison of major program types is included in the following section. Differences regarding key factors in the program have been categorized in accordance with the author's view of the evolution of employee assistance programs from the original industrial alcoholism programs, through the broad brush emphasis to comprehensive behavioral health programs. These comparisons represent a simplified conceptualization and do not reflect the wide range of actual program variations in current use. This conceptual analysis of important program variables provides the basis for the current study.

Accordingly, the supervisors were asked to respond to a variety of program issues at several levels of abstraction or specificity. The issues under study included the following topics: program philosophy, rationale, organizational elements, policy, and process. In addition, supervisors were asked to report on various aspects of their own experience with problem employees and the extent and manner of their own utilization of the program. The method utilized in this investigation is discussed in Chapter IV.

TABULAR COMPARISON OF MAJOR PROGRAM TYPES

PROGRAM CONCEPT

RATIONALE	**ALCOHOLISM**	**BROAD BRUSH**	**COMPREHENSIVE**
Purpose	Save money and reduce alcoholism.	Save money and help troubled employee.	Fair and effective resolution of behavioral health problems.
Primary beneficiary	Employer.	Employer and employee.	Mutual benefit to employer and employee.
Target population	Alcoholics.	Troubled employees.	Problem employees.
Need for program	Alcoholism is prevalent and costly to the employer.	Behavioral health problems are prevalent and costly to the employer.	Unresolved performance problems reflect behavioral health problems and require special intervention.
Method	Threat of dismissal motivates alcoholic employee to abstain and seek help if necessary.	Threat of dismissal motivates troubled employee to accept help.	Offer of help makes employee responsible for improved health and work performance.
Outcome	Abstinence leads to improved performance. Failure leads to dismissal.	Acceptance of treatment is usually effective and improves work performance.	Responsible employee utilizes help to restore performance or qualifies for benefits.
DYNAMICS			
Nature of problem	Alcoholism is an illness which is overcome by abstinence, i.e., responsible behavior; it is not the employee's fault.	Behavioral health problems are illnesses which require treatment. The working environment may contribute to the problem.	Behavioral health problems are maladaptive behaviors and require responsible action including acceptance of treatment; a healthy environment and good management foster health.
Role of work place	Use performance standards to identify and motivate alcoholics.	Use performance standards to identify and motivate troubled employees.	Offer treatment resource and rely on employment contract to elicit responsible behavior from problem employees.
Role of treatment	Treatment is not clearly defined. Medical model conflicts with behavioristic approach.	Treatment is essential and effective–based on medical model.	Professional treatment is often an important component in rehabilitation if coordinated with work place and appropriate to the problem. Psycho-social approach.
Role of problem employee	Obligated to behave responsibly.	Needs help due to illness.	Responsible for accepting assistance as needed.

Tabular Comparison of Major Program Types, continued

PROCESS

	ALCOHOLISM	BROAD BRUSH	COMPREHENSIVE
Prevention	Not a program responsibility–emphasis on training supervisors.	Includes training supervisors and informing employees of program.	Includes promotion of program use by employees, training of all managerial staff, and concern re healthfulness of working organization and environment.
Identification of Problem Employees	Supervisor is responsible to detect poor performance via documentation.	Supervisor is responsible to detect poor performance via documentation.	All managers are responsible to utilize the program when performance is a concern, employees are responsible to utilize the program if experiencing unresolved problems.
Motivation	Supervisor threatens dismissal (constructive coercion).	Supervisor utilizes progressive discipline.	Supervisor offers help and confronts employee with his responsibility within the contract.
Referral	Supervisor or management resource directs employee to alcoholism treatment facility and/or A.A.	Supervisor and/or program coordinator refers employee to community resource.	Diagnostic and referral service provides crisis intervention, selects appropriate treatment resources and coordinates treatment with work place.
Treatment	Employer provides sickness benefits for alcoholism. Lay treatment is an option.	Employer provides sickness benefits for behavioral health problems. Treatment is considered as a single event.	Employer provides professional treatment resource and sickness benefits for behavioral health problems and utilizes clinical consultation. Treatment is considered a complex, ongoing process.
Follow-up	Supervisor watches for relapse.	Supervisor watches for relapse.	Diagnostic and referral unit coordinates ongoing rehabilitation program, involves work place as rehabilitation resource and supervisor monitors ongoing performance.
Evaluation of Success	Success is equated with continued employment and adequate performance. Lack of recovery leads to dismissal.	Continued employment and adequate performance imply resolution of health problem. Lack of treatment success is handled "like any other illness".	Fair and effective resolution of performance problem = program success–may consist of (a) improved functioning, modified duties or provision of disability benefits if treatment is accepted or (b) improved performance or dismissal if treatment is rejected.

Tabular Comparison of Major Program Types, continued

PROGRAM COMPONENTS AND ROLES

	ALCOHOLISM	BROAD BRUSH	COMPREHENSIVE
Work Place	Serves as case-finding resource to alcoholism programs. Employee obligated to meet employer's standards.	Responsible for implementing program as cost control system and moral obligation. Employer obligated to help employee.	Program serves as vital element of effective management. Employer cooperates with treatment community, union, and the employee. Provision of positive work environment contributes to employee health.
Employer	Utilizes authority to identify and motivate alcoholic employees. Confronting stance toward employee.	Utilizes authority to identify and motivate problem employees—has some obligation to provide help. Paternalistic relationship with employee.	Provides assistance to problem employees and utilizes standard good management practices to identify and motivate employees who need help. Cooperative relationship with employee.
Supervisor	Represents employer—carries primary program responsibility.	Represents employer and has obligation to help employee with behavioral health problem.	Utilizes program to resolve his own dilemma regarding performance problems resulting from behavioral health problems—in consultation with senior manager and clinical resource.
Union	Should administer the program jointly with employer.	Role is ambiguous—may sponsor program independently.	Maintains traditional role of guarding employee rights and negotiating adequate benefits.
Treatment Agency	Is expected to provide help independent of the work place. Usually limited to one resource.	Is expected to resolve health problems medically and return productive employee. Various agencies may be involved.	Works in coordination with employer to provide appropriate treatment, utilize referral information and provide management recommendations to employer. Multiple resources may be involved.
Program Staff	Management or medical department is responsible for recommending treatment resource.	Lay program coordinator refers to treatment resource.	Professional clinical resource is provided by employer to coordinate all aspects of employee's rehabilitation.
Employee	Expected to behave responsibly by abstaining—considered responsible for his own problem.	Expected to accept help for illness—not responsible for problem but in need of help.	Confronted with responsibility for work performance and decision to accept treatment if needed.
Sponsors	Alcoholism industry promotes programs as case finding mechanism.	Employer expected to institute program for financial benefit and as moral obligation.	Management responsible to initiate program as means of improving behavioral health in organization. Lacks sponsorship of health organizations.

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CHAPTER IV

METHODOLOGY

DESIGN OF STUDY

Employee assistance programs are currently characterized by wide diversity in concept and practice. In the previous chapters, a need for research which is designed to resolve conflicts and clarify ambiguities concerning the program was revealed. However, these program characteristics have tended to preclude definitive research and generalization of research findings. The purpose of this study is, therefore, two-fold: a) to identify key issues in the program's rationale and relate these to each other in a consistent framework, and b) to describe the attitudes and opinions of supervisors with regard to these key issues. The nature of the subject matter, noted above, has also dictated several modifications in the research design.

IDENTIFICATION OF KEY ISSUES

In order to provide a basis for the present study, a critical review of the rationale for employee assistance programs was presented in Chapter III. Thus, Chapter III fulfills the preliminary purpose of the study by synthesizing the various viewpoints presented in the literature and identifying key issues. The basic issue concerns the heavy reliance on the supervisor by most programs and the lack of information about the supervisor's point of view. This issue is critical because of the indications that supervisors, in most programs, fail to utilize the program to any major extent.

DESCRIPTION OF SUPERVISOR'S VIEWPOINT

The primary purpose of this study is to provide a description of the supervisor's attitudes and opinions as they relate to the program. It is noted that the program is based on a number of assumptions concerning the supervisor, the structure and dynamics of the work place, and the nature of employee problems and their relation to treatment. The supervisor is clearly not qualified to make definitive statements about all of these areas. However, because of the supervisor's central responsibilities within the program, his point of view is important in that it reflects the basis for his decision concerning utilization of the program. In addition, the supervisor represents the employing organization at a practical level by virtue of his direct contact with the employee. It should be noted that the supervisor's attitudes and opinions are of interest, not only in relation to the stated program rationale, but also in relation to numerous assumptions on which the program is based.

The description of the supervisor's viewpoint has important applications in several areas. Firstly, it provides a basis for effective utilization of supervisors by providing a description of relevant supervisory characteristics. Secondly, the role of the work place in the overall program may be clarified on the basis of the dynamics which occur at the practical level of supervisor/employee relationships. Thirdly, the supervisor's viewpoint has important implications for the development of the employee assistance program concept because it identifies faulty assumptions and conflicts between the program concept and the realities of the work place. It should be noted that the focus of the study is on the concept of employee assistance programming rather than on the characteristics of supervisors.

TYPE OF STUDY

This is a descriptive study employing questionnaire and interview data-gathering techniques. A sample of supervisors in a variety of employing organizations in Edmonton, Alberta was selected. The selection process was designed to maximize the validity of responses obtained by including organizations with a wide range of program types and by including supervisors to whom the program would be relevant. A wide range of questions were included in the study, in keeping with Good's (1959) recommendation that "one should aim . . . at a fairly full bodied attack" (p. 171).

RESEARCH QUESTIONS

The specific questions under study were derived from a critical review of the existing literature presented in Chapter III. The questions were designed to provide a comprehensive view of the supervisor's perspective and were organized according to their level of concreteness and specificity.

HOW SUPERVISORS VIEW THE PROGRAM

The primary question concerns the supervisor's opinions and attitudes concerning the concept of employee assistance programming and, more specifically, the assumptions on which the programs are based. These questions include the following:

1. What is the supervisor's view of the program's philosophy, i.e., its purpose, the concept of cooperation between the work place and the treatment community, and the role of the supervisor?

2. What is the supervisor's view regarding the program rationale, i.e., the need for programs, the method of motivating problem employees to accept treatment and the efficacy of treatment?

3. What is the supervisor's view of various program elements, i.e., the union, the employer, and the treatment agency?

4. How do supervisors regard the program's policy statements, including key elements of policy as well as various additional statements frequently included?

5. What is the supervisor's view of the program process, i.e., identification of problem employees, motivation to accept treatment and referral to treatment?

PROGRAM UTILIZATION BY SUPERVISORS

The second major question concerns the extent to which supervisors utilize the program in actual practice. In this section supervisors were asked:

1. the frequency with which problem employees were identified in the previous year;

2. how supervisors dealt with these problem employees;

3. how the employees responded to the supervisor's action;

4. what the outcome of the methods actually utilized by supervisors was in dealing with problem employees.

The primary purpose of this set of questions was to provide a context within which the responses to the remaining questions could be interpreted. It was hypothesized that supervisors utilized the program only with a minority of problem employees.

FACTORS AFFECTING THE SUPERVISOR'S VIEW OF THE PROGRAM

Supervisors were compared according to a variety of criteria which have been suggested as contributing to differing levels of program utilization. Comparisons were made on the basis of age, sex, knowledge of the program, level of supervisory position and union vs. exclusively management affiliation. A comparison of supervisors in different types of programs had been planned but was not possible because an insufficient number of supervisors were knowledgeable enough about the program to make a valid comparison.

SAMPLE SELECTION

THE SAMPLE

A representative sample of supervisors was selected from employing organizations in Edmonton, Alberta. The employing organizations included: Alberta Government Telephones, the City of Edmonton, Labatt's Alberta Breweries, Canadian National (Railways), Alberta Government Services and the Department of Recreation, Parks and Wildlife in the Government of Alberta. The selection of employers approximates the finding by Desjardins (1977) that half of Canadian programs are located in industry and the other half are located in service or government employing organizations. It is noted, however, that of the employers in this study, two are crown corporations rather than private industries and no service organizations were included.

The employing organizations included in the study may reasonably be assumed to be typical of Canadian employers with active employee assistance programs. The historical development of these programs appears typical of Canadian programs generally (Corneil, 1976; Cutler and Jones, 1976) although some of the programs, notably Alberta Government Telephones, were established much earlier than the norm. The programs themselves represent a typical range of program types and are based on a common, although diverse, body of program literature. Four of the programs are officially designated as alcoholism programs although the program coordinators stated that in practice the programs are broadening their scope to include other types of problems. The programs within the provincial government are comprehensive behavioral health programs which include alcoholism in their scope.

The various employers' program policies may be briefly described as follows. Alberta Government Telephones (AGT) directs its policy toward "problem drinking, alcoholism and drug abuse". Supervisors are encouraged to be aware of signs and symptoms displayed by alcoholics. Final disciplinary action is delayed until treatment refusal or failure is demonstrated. However, temporary discipline may be used as a motivating force when more constructive pressures fail. The supervisor refers problem employees to the medical center or he may recommend that the employee seek treatment on his own. The medical center refers employees to the Alberta Alcohol and Drug Abuse Commission (AADAC) and obtains information from AADAC for the company's use (AGT, 1978).

The City of Edmonton (EDM) has a policy on alcohol and drug abuse. Supervisors are instructed to identify problem employees on the basis of poor work performance which is due to suspected illness. Supervisors are warned not to diagnose the problem. If the employee fails to accept treatment his case is treated as a disciplinary problem. Unacceptable work performance does not entail discipline, however, if the referral is accepted and the employee follows through. The director of Occupational Health and Safety diagnoses the problem and refers the employee to AADAC. (City of Edmonton, 1978).

Labatt's Alberta Breweries (LAB) also directs its policy toward alcohol and drug abuse. The company adopted the policy "as a responsible employer and corporate citizen" and it is intended to provide constructive assistance to employees. Problem employees may be identified by the supervisor, nurse or personnel manager and employees are encouraged to refer themselves for treatment on a voluntary basis. When decreased work performance is noted by the supervisor he is required to document this and confront the employee. If the performance problems are clearly due to drinking, treatment is considered mandatory. The employee may be dismissed only if medical treatment and other measures have failed. The company provides treatment through the medical and personnel departments. However, the supervisor is responsible for referring the employee to the company doctor, i.e., available full time at head office or on a consulting basis locally (Labatt's 1975).

The Canadian National Railways (CNR), Mountain Region, directs its policy toward problem drinking and alcoholism. Alcoholism is considered to concern management if it affects work performance. Employees are encouraged to contact a counsellor within the program voluntarily. (Lay counselling is provided by a full-time and a number of part-time counsellors.) The policy lists a number of symptoms which differentiate alcoholism from social drinking. Managers and supervisors are trained to identify early signs of problem drinking. Dismissal is considered if minimum performance standards are not met. In addition, drinking on the job or intoxication on the job results in discipline regardless of program involvement by the employee. The medical officer is responsible for diagnosis and recommending appropriate treatment programs (CNR, 1973).

Recreation, Parks and Wildlife (RPW) and Alberta Government Services (AGS) both operate under the policy of the Alberta government which is directed toward any behavioral health problem. Employees are encouraged to refer themselves to the Diagnostic and Referral Unit which is provided by the government. Supervisors refer problem employees on the basis of inadequate work performance and are encouraged to do so in consultation with the Diagnostic and Referral Unit. The program is based on an active offer of help to employees in the context of the employee's obligation to maintain adequate work performance. Failure to accept referral or to benefit from treatment results in simply reverting the case to normal administrative and/or disciplinary procedures. Employees may be referred to the Diagnostic and Referral Unit by supervisors or personnel officers. The Unit provides an assessment of the problem, short-term counselling or psychotherapy and referral to community treatment agencies. In addition, the Unit provides coordination of treatment services and consultation to supervisors with regard to work-related aspects of the behavioral health problem (Alberta Public Service, 1978).

SELECTION PROCESS

Consultation with Community Extension Services, AADAC, was utilized to construct a list of employing organizations in the Edmonton area which were thought to have active employee assistance programs or known to have expressed interest in establishing programs. The most active programs were identified through direct contact with each organization. A total of seven organizations were considered to have sufficiently active programs to be included in this study. However, of these, one organization, from outside Edmonton, was unable to participate because of a drastic slow-down during the summer holiday season. Consequently, the participating organizations include all of the most active programs known to exist in the City of Edmonton.

The program coordinator in each employing organization was approached initially on an informal basis. Formal approval for participation in the study was obtained through correspondence and, in most cases, personal representation to senior management.

Discussions with the various personnel directors were conducted to identify specific sections in the organization to be involved in the study. This was done to minimize the disruption to the organization and to facilitate and simplify administrative arrangements for contacting supervisors. These sections were selected on the basis of their accessibility, their representativeness of the entire organization and the probability that supervisors in these sections would meet the selection criteria listed below. The selected sections included the following.

AGT–Equipment Installation (North)
–District Outside Plant Engineering and Construction (Edmonton)
–District Operator Service (Edmonton)

EDM–Parks and Recreation Department–Administration
–Operations District (Southwest)

LAB–The total management and supervisory staff was included

CNR–Diesel Shop and Servocentre (Operations and Carload)

AGS–Physical Plant (Central Region and Northwest Region)
–Operating and Maintenance Division (Shops and Services)

RPW–Fish and Wildlife Division
–Administrative Division

A total of 269 supervisors at all levels of these organizations were included in the designated sections. In order to achieve a sample size of 150, a total of 166 supervisors were selected, allowing for an estimated 10% attrition rate due to extended holidays, postings outside of Edmonton or unavailability due to unforeseen circumstances. Accordingly, 28 supervisors were randomly selected from each organization, using a table of random numbers. The only exception occurred at Labatt's where only 26 supervisors were known to be potentially available during the period of the study.

The above selection process resulted in a total sample of 145 supervisors. The sample sizes for each employing organization ranged from 23 to 27 supervisors. Thus, the rate of return for the entire sample group was 87%. The primary reasons for non-participation included absence due to holidays and designation of supervisory positions which were found to be vacant. Four supervisors were deleted because they were found not to meet the above criteria.

In each case the personnel director or the senior manager was asked to provide a list of all supervisors in the designated sections by applying the definition provided in Chapter I of the study. The sections included in the study were chosen with a view to including supervisors who would be most likely to be able to utilize the program effectively on the basis of adequate knowledge of the program, a relatively stable employee population and a clearly defined supervisory role. Specific criteria for inclusion of supervisors in the sample were (a) they must have access to the normal training offered to supervisors, (b) they must have direct supervisory responsibility for a number of staff, (c) they must be clearly responsible for formal supervisory functions, (d) they must have worked in a permanent staff area for the past year, i.e., not primarily with temporary or seasonal staff. However, supervisors who had prior experience with the program were included even if they had been in their present position for less than one year. It should be noted that all programs had been in operation for more than one year at the time of the study.

THE QUESTIONNAIRE

DESIGN

Because of the absence of research concerning the supervisor's view of employee assistance programming, a new questionnaire had to be developed for this study (Appendix A). The questionnaire items were developed from a comprehensive review of the literature. The items were organized by sections which were designed to maximize their relevance to supervisors and to flow in a logical sequence. The sections include (a) personal information, (b) experience with problem employees, (c) general view of the program, (d) how the program works, and (e) the supervisor's role.

The items relate to the research questions stated above as follows:

(1) program philosophy–section C
(2) program rationale–section D, items 1 through 8 and 10 through 12
(3) program elements–section D, items 13 through 19
(4) program policy–section D, items 20 through 29
(5) program process–section E, and section D, item 9
(6) program practice–section B

The major portion of the questionnaire consisted of a Likert scale measuring agreement or disagreement with statements about the program, a rank ordering of items representing differing viewpoints in order of importance, and numerical responses quantifying the number of employees in various categories of actions and reactions currently involved in resolving work performance problems.

VALIDATION

During the initial construction of the questionnaire, items and format were discussed with a number of supervisors and individuals experienced in research methodology. Several supervisors completed the questionnaire and provided valuable subjective feedback.

After extensive revision, the questionnaire was submitted to several faculty members at the University of Alberta and their recommendations were incorporated. A pilot study was then conducted including seven supervisors randomly selected from a staff training course and five supervisors from CNR. Comments were elicited from each participant and the data were inspected with a view to clarifying ambiguous items, definitions and instructions as well as testing the appropriateness of group administration of the questionnaire. A final revision of the questionnaire was then submitted to a faculty member for a review of accuracy, format and comments concerning administration.

DATA COLLECTION

QUESTIONNAIRE COMPLETION

Each supervisor was contacted by his personnel director or senior manager to request his participation in the study. This "company representative" sent each supervisor a letter on company letterhead stating the company's approval of the study, a brief explanation of its purpose and assurance of confidentiality of employee information. The letter explained the basis for the supervisor's selection and designated times and locations for questionnaire completion. (At Labatt's this process was carried out in person rather than by letter.)

Each supervisor was also provided with a work sheet concerning section B of the questionnaire so that he could prepare accurate data concerning the number of employees dealt with in the previous year (Appendix B). In some cases, the researcher also provided, at the company representative's request, a brief summary of the nature and purpose of the study. Finally, the supervisors were asked to confirm their willingness and ability to attend at the specified times or to contact the company representative for alternate arrangements.

The questionnaires were administered under the researcher's supervision in group sessions. This method was selected in order to ensure a high rate of return and to maximize the validity of responses in view of the complex nature of the questions. The supervisors were assured that the results of the study would be made available through their employer. In addition, the supervisors were advised that some of them would be randomly selected for a follow-up interview.

The above procedures resulted in a high rate of return (87%) and careful, thoughtful questionnaire completion by most supervisors. A number of supervisors noted that the questionnaire would provide a useful basis for inservice training and most appeared to find the questionnaire completion a positive experience.

In a number of instances, scheduling problems precluded a supervisor's participation in the group sessions. In most of these cases the questionnaire was administered in a similar fashion on an individual basis. In one case the personnel director administered the questionnaire to several supervisors after careful instruction in the administration process. In two cases the supervisor completed the questionnaire on the basis of telephone contact with the researcher.

INTERVIEWS

Five supervisors were selected for a follow-up interview from each employing organization. The selection was again done randomly through the use of a table of random numbers. Of the thirty supervisors selected for interviews, a total of 27 participated and were included in the study. Of the remaining three, one was unavailable because of a foreign posting, one was unable to participate because of scheduling problems and one was excluded from the study because he was found not to meet the criterion of directly supervising permanent staff.

The supervisors were interviewed individually and all interviews were tape recorded except for the supervisors from AGT where permission to record interviews had been refused by the company and one other supervisor who objected personally to being recorded. The tape recordings and interview notes were then reviewed and summarized (Appendix C). The interview data were then utilized in enhancing the interpretation of the questionnaire results.

The interviews were essentially unstructured. However, the interviews focused on clarification of the supervisor's responses on the questionnaire, discussion of his general view of the program and description of his involvement with a specific problem employee from his past experience.

ANALYSIS OF DATA

The nature of the study dictates the use of descriptive data. The questionnaire data were transcribed onto computer coding sheets and key punched onto computer cards two times to ensure accuracy. All data were coded by employer and by individual supervisor. The data are presented in descriptive form including means, distributions and standard deviations. Tests of significance were not considered appropriate due to the lack of control for numerous intervening variables, the descriptive purpose of the study and the study's focus on the program concept rather than differences among supervisors.

The data were interpreted on the basis of observed results and with the aid of narrative data from the interviews. The interview data had been treated as noted above and a number of opinions, mentioned by a large percentage of interviewees, were tallied. The primary comparisons made in the study involve the relationship between the research data and the assumptions on which programs appear to be based. A secondary set of comparisons involves the differences between the various subgroups of supervisors, again with a view to identifying important program characteristics and amplifying the basis for plannning further program development.

LIMITATIONS OF THE STUDY

The limitations of survey studies listed by Good (1959) have been carefully considered. Good notes that survey respondents cannot provide reliable information concerning issues which are not salient to them or about which they do not have information. In the present study supervisors have been asked to comment on a number of issues concerning the employing organization and the treatment process which are somewhat outside their own area of knowledge and responsibility. However, it has been suggested that the supervisors' attitudes concerning these topics have a direct bearing on their own behavior. Therefore, care must be taken to interpret the supervisor's responses as significant attitudes rather than as objective statements of fact.

The results should also not be interpreted to reflect the opinions of all supervisors in all settings. The sample of supervisors was selected on the basis of their likelihood to have valid opinions concerning program issues, i.e., they work for employers with active employee assistance programs, have not been excluded from regular training programs and supervise a stable employee population. It is noted that no very small employers were included in the study. Also, the study is limited to Canadian employers and should not be generalized to American settings unless further studies demonstrate that this is valid.

A number of limitations also result from the fact that no similar studies have been reported in the literature. Consequently, a new questionnaire had to be designed and much of its content was based on inferences from the literature. The study should, therefore, be recognized as a preliminary investigation in this area and will hopefully provide a basis for more rigorous research in future.

CHAPTER V

PRESENTATION AND DISCUSSION OF FINDINGS

The findings of this study are presented in two sections. The first section includes data from the entire questionnaire, interpreted in the context of the interviews. The data are organized by employer and total group. For ease of comparison, the employers are grouped as follows. The first three employers represent government (provincial and municipal) and the last three are companies (private and crown corporations). In addition, the first pair of employers have a comprehensive behavioral health program, the last pair have a narrow, alcoholism or/and drug abuse program and the middle pair have a somewhat mixed program, although the official focus is on alcoholism.[1] Rank order data are presented throughout the study in the order of importance established by the total group.

The second section also includes questionnaire data. However, in this section comparisons are made between supervisors who differ on several characteristics which are thought to correlate with differences in program perception and utilization.

FINDINGS FOR TOTAL GROUP–BY EMPLOYER.

DEMOGRAPHIC DATA

AGE

Approximately 70% of the supervisors were between thirty and fifty years of age. Table 1 shows the distribution of supervisors by age. In addition, the percentage of the total sample comprised by each employer is given.

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[1] See program types, pages 30 and 31.

Table 1

SUPERVISORS' AGE DISTRIBUTIONS

Employer *	Age, in years <20	20–29	30–39	40–49	50–59	≥60	No Answer	% of Total Group	N
RPW		8.7%	47.8%	21.7%	21.7%	0.0%		15.9%	23
AGS		3.7	18.5	51.9	18.5	7.4		18.6%	27
EDM		17.4	34.8	30.4	17.4	0.0		15.9%	23
LAB		13.0	30.4	39.1	13.0	4.3		15.9%	23
CNR		12.0	40.0	28.0	20.0	0.0		17.2%	25
AGT		8.3	33.3	45.8	8.3	0.0	4.2	16.6%	24
Total		10.3%	33.8%	36.6%	16.6%	2.1%	0.7%	100.0%	
N =		15	49	53	24	3	1		145

*RPW–Recreation, Parks and Wildlife, Government of Alberta
AGS–Alberta Government Services
EDM–City of Edmonton, Alberta
LAB–Labbatt's Alberta Brewery
CNR–Canadian National Railways
AGT–Alberta Government Telephones

SEX

Table 2 shows a preponderance of male supervisors. This appears to be consistent with the actual distribution by sex of supervisors in most organizations.

SUPERVISORY EXPERIENCE

In Table 3 the supervisors' years of experience in a supervisory position are presented. The average participant in the study had been a supervisor for over ten years. The average length of supervisory experience varies relatively little among employers.

SENIORITY

The distribution of years spent with the present employer is presented in Table 4. The supervisors had been employed in their present organization for an average of over fourteen years. Thus, the average supervisor had been with his present employer for four years before becoming a supervisor. However, this varied considerably among employers.

UNION/MANAGEMENT AFFILIATION

Supervisors were asked to indicate whether they identified with management or the union. Table 5 shows that the majority of supervisors identified themselves exclusively as managers. However, in contrast with company employers, a majority of supervisors in government stated that they were union members with supervisory duties.

LEVEL OF MANAGEMENT POSITION

Supervisors were asked to describe their employees by type of work and by level of position. Table 6 shows the distribution of supervisors who have employees in various types of work. A good mixture of categories is indicated.

In Table 7 the supervisors are categorized by the position of their subordinates. Most of the sample appear to be front line supervisors who are responsible for nonsupervisory employees. However, the entire sample appears representative of the usual management hierarchy.

Table 2

Distribution by Sex

Employer	Male	Female
RPW	78.3%	21.7%
AGS	96.3	3.7
EDM	91.3	8.7
LAB	100.0	0.0
CNR	100.0	0.0
AGT	58.3	41.7
% of Total Group	87.6	12.4
N =	127	18

Table 3

Total Number of Years in a Supervisory Position

Employer	Years						Average
	1–5	6–10	11–15	16–20	21–25	Over 25	
RPW	30.3%	26.0%	26.0%	17.3%	15.9%	0.0%	10.2 years
AGS	22.2	14.8	29.6	25.9	26.0	0.0	12.2
EDM	26.0	30.3	21.5	13.0	15.9	8.7	11.2
LAB	25.9	26.1	34.7	4.3	20.2	4.3	10.8
CNR	36.0	28.0	24.0	0.0	25.2	4.0	9.8
AGT	58.3	16.8	4.2	12.5	25.0	0.0	8.2
% of Total Group	33.1	23.5	23.5	12.5	4.9	2.8	10.4

Table 4

Total Number of Years With Present Employer

Employer	Years						Average
	1–5	6–10	11–15	16–20	21–25	Over 25	
RPW	43.5%	13.0%	26.1%	8.7%	0.0%	8.7%	10.3 years
AGS	22.0	11.1	14.8	18.5	22.2	11.1	15.9
EDM	13.0	30.4	21.7	13.0	17.4	4.3	12.5
LAB	34.8	21.7	43.5	0.0	0.0	0.0	9.5
CNR	4.0	12.0	24.0	12.0	8.0	40.0	20.0
AGT	12.5	8.3	20.8	25.0	12.5	20.8	17.2
% of Total Group	21.4	15.9	24.8	13.1	11.7	14.5	14.4

Table 5

Union/Management Affiliation

Employer	Management Only	Management & Union	Union Member	Neither	No Answer
RPW	26.1%	4.3%	56.5%	13.0%	0.0%
AGS	33.3	0.0	59.3	3.7	3.7
EDM	34.8	4.3	60.9	0.0	0.0
LAB	78.0	0.0	0.0	27.7	0.0
CNR	92.0	0.0	8.0	0.0	0.0
AGT	87.5	4.2	0.0	4.2	4.2
% of Total Group N = 145	58.6	2.1	31.0	6.9	1.4

Table 6

Level of Employees Supervised: By Type of Work

Employer	Number of Supervisors Who Supervise:				
	Unskilled	Skilled	Clerical	Trades	Professional
RPW	0.0%	52.2%	73.9%	8.7%	47.8%
AGS	29.6	44.4	22.2	48.1	14.8
EDM	17.4	69.6	47.8	0.0	13.0
LAB	52.2	34.8	17.4	17.4	17.4
CNR	36.0	36.0	52.0	40.0	0.0
AGT	12.5	54.2	20.8	37.5	0.0
% of Total Group* N = 145	24.8	48.3	38.6	26.2	15.2

*Categories are not mutually exclusive.

Table 7

Level of Employees Supervised: By Position

Employer	Number of Supervisors Who Supervise:			
	Non-supervisory Employees	Junior Supervisors	Management Level Supervisors	Senior Managers
RPW	78.3%	52.2%	13.0%	8.7%
AGS	85.2	37.0	11.1	3.7
EDM	73.9	39.1	13.0	4.3
LAB	78.3	21.7	13.0	4.3
CNR	80.0	24.0	32.0	0.0
AGT	91.7	33.3	16.7	0.0
% of Total Group* N = 145	81.4	34.5	16.6	3.4

*Categories are not mutually exclusive.

KNOWLEDGE OF PROGRAM

The supervisors were asked if they knew how to use their employer's employee assistance program. Table 8 shows that only about one-quarter felt confident that they did know how to use the program. However, approximately three-quarters knew how to use the program at least to some extent. Knowledge of the program was lowest for the government employers.

Table 9 lists the ways in which supervisors obtained knowledge about the program. Policy distribution and special seminars comprise the most frequently utilized formal methods. In addition, many supervisors heard about the program indirectly or received personal consultation from the senior manager or program staff. Supervisors in government had received information from fewer sources than did company supervisors. Over all, these results indicate a lack of adequate program information for supervisors.

EXPERIENCE WITH PROBLEM EMPLOYEES

IDENTIFICATION OF PROBLEM EMPLOYEES

Supervisors were asked several questions about the number of employees under their supervision (Table 10). They reported that they were supervising an average of 20.7 employees directly and had supervised an average of 35.8 employees during the previous year. It should be noted that these numbers are strongly affected by the CNR sample which utilizes team management in a shift work situation. Without the CNR group, the average number of employees supervised directly was 8.6 and 14.7 indirectly. Of the total group, 56.6% of the supervisors reported indirect supervisory responsibility for an average of 96.2 employees. This suggests that senior managers could have a highly significant role in identification of problem employees because they have some supervisory responsibility for such a large number of employees.

Table 8

Knowledge of How to Use Employer's Program

Employer	Know	Don't Know	Know to Some Extent	No Answer
RPW	8.7%	56.5%	30.4%	4.3%
AGS	29.6	29.6	37.0	3.7
EDM	13.0	39.1	39.1	8.7
LAB	43.0	8.7	47.8	0.0
CNR	36.0	4.0	60.0	0.0
AGT	29.2	0.0	70.8	0.0
% of Total Group N = 145	26.9	22.8	47.6	2.8

Table 9

How Program Knowledge Was Obtained

Employer	Regular Training Session	Special Seminar	Read Detailed Description	Received Policy	By Using It	Personal * Consultation	Indirectly	Other	No Information Received	Utilization ** of Information Sources
RPW	8.7%	17.4%	4.3%	13.0%	4.3%	13.0%	26.1%	4.3%	30.4%	11.4%
AGS	11.1	11.1	11.1	25.9	14.8	22.2	25.9	7.4	7.4	16.2
EDM	0.0	17.4	8.7	30.4	8.7	8.7	17.4	13.0	39.1	13.0
LAB	17.4	34.8	21.7	43.5	26.1	21.7	30.4	0.0	4.3	24.5
CNR	20.0	20.0	28.0	44.0	16.0	24.0	40.0	0.0	0.0	24.0
AGT	20.8	29.2	16.7	66.7	4.2	20.8	4.2	12.5	0.0	21.9
% of Total Group	13.1	21.4	15.2	37.2	12.4	18.6	24.1	6.2	13.1	

*With a senior manager or program staff member.

**By average % of supervisors utilizing the sources listed.

Table 10

Identification of Problem Employees (by mean number of employees per supervisor)[1]

Employer	Number of Employees Supervised at Present		Employees Directly Supervised During Past Year			N
	Directly	Indirectly	Number	Number of Problem Employees		
				Number	% of Total	
RPW	3.5	8.4	4.5	1.0	23.3	23
AGS	8.5	114.1	10.3	1.6	15.4	27
EDM	3.5	9.2	7.7	.5	6.7	23
LAB	18.7	28.6	29.8	3.9	13.7	23
CNR	79.6[2]	109.1	139.9	17.6	13.1	25
AGT	8.6	42.6	38.5	1.5	6.3	24
For Total Group	20.7[3]	55.2	35.8[4]	4.5	12.6	145
% of Supervisors Actually Involved	98.6	56.6	98.6	56.6		

[1] Based on total number of supervisors per group.

[2] CNR uses team management in a shift work situation.

[3] Would equal 8.6 if CNR is excluded.

[4] Would equal 14.7 if CNR is excluded.

The most significant finding in this section was the supervisors' report that they were aware of a 12.6% incidence of problem employees. This compares to a frequently estimated total incidence of acoholism in the work place of 5.3% and a target identification rate of 1% annually (Van Wagner, 1978). Subsequent data (Tables 11 and 12) show that only a small percentage of known problem employees were involved in the assistance program. This highlights the fallacy of the assumption that supervisors will utilize the program if they learn to recognize problem employees. This finding supports the contention that supervisors recognize many problem employees but hesitate to identify them formally because this constitutes a decision to utilize the program. It is noted that one or more problem employees were identified by 56.6% of all supervisors.

CORRECTIVE ACTION TAKEN BY SUPERVISOR

Table 11 shows how supervisors dealt with problem employees. These figures include all actions reported by supervisors and average 1.3 actions per problem employee.

The findings show that the supervisors relied most heavily on informal problem solving and secondly on discipline or reprimand to resolve work performance problems. Immediate dismissal was used very seldom. Formal constructive coercion was used with only 11.5% of all problem employees and 6.5% were offered voluntary referral for professional assistance.

Supervisors were also asked to indicate who had been responsible for taking the corrective action. Where action was taken jointly by the supervisor and a senior manager, the supervisor was asked to indicate who had taken responsibility for initiating the action. It was found that a large majority of corrective actions were initiated by the immediate supervisor. Senior managers were most often involved in initiating dismissal and recommending or arranging a job change. They were also responsible for initiating an offer of referral or using constructive coercion in approximately 30% of the cases where these options were utilized. This again suggests the importance of involving senior managers in the program.

Table 11

Corrective Action Taken by Supervisor

Total Actions Taken	N*	Number of Employees	Percent of All Problem Employees	Action Taken by		Not Indicated
				Supervisor	Senior Manager	
No action	22	82	12.7	61%	8.5%	30.5
Informal problem solving	63	389**	60.3	97.2	2.1	.8
Discipline or reprimand	39	195	30.2	81.0	18.5	.5
Offer of voluntary referral for professional assistance	23	42	6.5	69.0	31.0	0
Recommend or arrange job change	31	53	8.2	58.5	39.6	1.9
Formal constructive coercion	20	74	11.5	70.3	29.7	0
Immediate dismissal	7	20	3.1	60.0	40.0	0
Totals		855		710	115	30
		(1.33 Ave.)		(83%)	(13.5%)	(3.5%)

*N = number of supervisors responsible for corrective actions taken with regard to problem employees indicated in next column.

**Includes one estimate of 140 employees from a group of 150 problem employees.

EMPLOYEE RESPONSE TO CORRECTIVE ACTION

Supervisors were asked to indicate how employees had responded to the most intensive corrective action which had been applied to them. Informal problem solving was the most intensive action utilized in almost one-half of the cases. Constructive coercion was used twice as often as an offer of voluntary referral but, together, these options were used with only 11% of all problem employees as the most intensive action. (Table 12)

For all corrective actions utilized, the success rate was 53.6% as measured by job retention and improvement of work performance. 8.4% resigned or were dismissed and 32.7% of the problem employees remained on the job with no improvement in performance. The highest percentage of success, as defined above, was obtained by use of reprimand or discipline and through informal problem solving. Failure to take any corrective action was the least successful strategy. Constructive coercion and voluntary referral were no more successful than the average for all types of action. However, the intensity of the problem was not taken into account in these calculations. It is noted that in one-third of the cases reported, the offer of help was refused. However, approximately twice as many employees accepted help when faced with constructive coercion as compared to being offered a voluntary referral.

OUTCOME OF CORRECTIVE ACTION

At the time of the study, approximately 86% of all problem employees were still employed by the same employer (Table 13). Of the total group, approximately 61.5% of the problem employees were performing at a fully satisfactory or nearly satisfactory level.

Approximately 14% of the problem employees had left their jobs. Of these, the majority had resigned and most of the remainder had been dismissed. Almost one-quarter of the problem employees were still employed but performing at an unsatisfactory level or off the job due to sick leave, leave of absence, etc.

The above data indicate that a significant number of employee problems are

Table 12

Employee Response to Corrective Action (by % of employees to whom each action was applied)

	Most Intensive Supervisory Action						% of All Problem Employees
	No Action	Informal Problem Solving	Reprimand or Discipline	Offer Voluntary Referral	Recommend Job Change	Constructive Coercion	
Offer of referral was							
Accepted				32		33.3	3.6
Refused				20		8.9	1.4
(Not indicated)				(48)		(57.8)	(5.9)
Employee remained and work performance							
Improved	34	60.5	63.6	48	37.7	53.3	53.6
Did not improve	61.7	37.9	27.3	24	24.5	17.8	32.7
OR							
Employee left							
Quit	–	.6	9.1	12	9.4	13.3[1]	4.3
Transferred	2.1	–	–	–	17	2.2	1.7
Was Dismissed						11.1	.8
Employee response not indicated[2]	2.1	1.0	–	16	11.3	2.2	2.5
Number of employees involved (% of all problem employees)	7.3	48.7	20.5	3.9	8.2	7.0	95.5[3]

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[1] About two-thirds of the employees were reported to have improved their work performance before quitting.

[2] With regard to performance or continued employment.

[3] 3.1% of all problem employees were immediately dismissed. Of these, 70% grieved their dismissal and lost the grievance. 25% did not grieve and 5% were not indicated.

Table 13

Outcome in Terms of Employment

N = 628[1]

Problem Employees Who Are:

	Still Employed		No Longer Employed		
Work Performance Is:	Number	% of All Problem Employees	Reason	Number	% of All Problem Employees
Fully satisfactory	111	17.7%	Resigned	52	8.3%
Nearly satisfactory	276	43.9	Dismissed	26	4.1
Not satisfactory	140	22.3	Retired	6	1.0
(Not Applicable)[2]	12	1.9	Deceased		.3
			Other		.5
Totals	539	85.8%		89	14.2%

[1] The outcome was not known regarding 17 (2.6%) of the 645 problem employees identified—frequently because the employee or the supervisor had been transferred.

[2] Due to extensive leave of absence, etc.

not currently being resolved, even though an employee assistance program has been adopted. In addition, it appears that programs are not particularly effective in resolving employee problems even in those cases where the program is utilized. In this context, the supervisors' opinions and attitudes concerning program issues are presented under the next heading.

THE SUPERVISOR'S VIEW OF THE PROGRAM

The supervisors were asked to rank order a number of items concerning the program's purpose and concept and the supervisor's role in the program. These items represent major viewpoints and assumptions expressed in the literature.

PROGRAM PHILOSOPHY

The supervisor's perception of the program's purpose and conceptual basis is presented in Table 14. The data reveal a number of important discrepancies between the supervisor's view and commonly accepted assumptions about the program.

The supervisors indicated that the most important purpose of the program is to assist troubled employees. Of the remaining reasons for having a program, the employer's interest in saving money rated last and society's (and the alcoholism industry's) interest in reducing illness was considered similarly unimportant. (See mean values, Appendix B, Table A.) The supervisors also rated the employee as the primary beneficiary of the program. The employer was considered to benefit more than the supervisor. This suggests that supervisors do not see the program as being particularly helpful to them as Trice (1971) had suggested it should be.

The supervisors also reject the contention that alcoholism represents the greatest cause of poor work performance. A variety of other behavioral health problems are considered the most important factors, followed by factors in the work situation and the employee's lack of ability or training.

The supervisors also rejected the idea that their own confrontation of the employee with a threat of dismissal (constructive coercion) is the most important method

Table 14

The Supervisor's View of Program Philosophy (Rank Order by Importance of Item)

Item	Employer							
	RPW	AGS	EDM	LAB	CNR	AGT	Total	No Response*
				PURPOSE OF PROGRAM				
Program purpose is to:								
Assist employees	1	1	1	1	1	1	1	0
Assist Supervisors	2.5	2	2	2.5	3	2	2	4
Improve Organization	2.5	3	3	2.5	2	3	3	4
Reduce illness	5	4	4	4	4	4.5	4	14
Save money	4	5	5	5	5	4.5	5	16
Program Benefits:								
Employee	1	1	1	1	1	1	1	0
Employer	2	2	2	2	2	2	2	2
Supervisor	3	3	3	3	4	3	3	5
Society	4	4	4	4	3	4	4	9
Union	5	5	5	5	5	5	5	29
				PROGRAM CONCEPT				
Poor Work Performance is Due to:								
Other behavioral health problems	2.5	2	2	1	1.5	1	1	3
Work situation	1	4	3	2	4	2	2.5	9
Lack of ability/training	2.5	3	1	4.5	1.5	3	2.5	10
Alcoholism	4.5	1	4	4.5	3	5	4	8
Inappropriate management	4.5	5	5	3	5	4	5	17
Source of Motivation:								
Personal Responsibility	1	1	1	2.5	2	1	1	6
Family & social pressure	3	3	2.5	1	4.5	2	2	5
Situational crises	2	4.5	5	2.5	3	4	3.5	9
Confrontation by supervisor	5	2	2.5	5	1	3	3.5	8
Professional/medical information	4	4.5	4	4	4.5	5	5	5
Treatment effectiveness depends on:								
Attendance by employee	2	1	1	1	1	1	1	5
Appropriateness	1	2	2	2.5	3	3	2	4
Accessibility	3	3	3	2.5	2	4	3	4
Quality of service	4	4	4	4	4	2	4	6
Coordination with work place	5	5	5	5	5	5	5	17

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*Participants were instructed to leave an item blank if it was not important at all. However, these non-responses were not included in the calculation as they would not have significantly altered the rank order of items.

of motivating problem employees to accept treatment. Instead, they stressed the employee's personal responsibility to seek help and the importance of family and social pressure. The supervisors did not agree that professional/medical information and recommendations are an important source of motivation.

Supervisors did, however, agree with the assumption that treatment will be effective if only the employee can be persuaded to attend. Coordination of treatment with the work place was not considered, at a philosophical level, to be important in making treatment effective. However, data presented later show a much greater appreciation of such coordination at a practical level. In the follow-up interviews, a general lack of appreciation for the treatment agency's perspective was noted. A number of supervisors stated that they consider treatment as an isolated function (like having a pair of boots resoled–Interview No.2).

Few major differences of opinion were noted among the employer groups. This indicates the existence of relatively consistent views among supervisors regarding program philosophy, which are not greatly affected by differences among employing organizations.

THE SUPERVISOR'S ROLE

Table 15 describes the supervisors' perception of their own role in the program. The supervisors endorsed the concept that they are responsible to face the employee with his responsibilities although they had previously indicated (Table 14) that confrontation by the supervisor is not an important source of motivation. The supervisors also indicated that they are responsible for involving the employee in treatment and do so as the representative of the employer's interest. Although numerous writers have emphasized the supervisor's responsibility to get the job done, this was not given high priority.

The supervisors ranked their immediate superior as clearly being their primary resource in dealing with a problem employee. The employee assistance counsellor was ranked second in spite of the fact that most of these programs do not provide one. In comparison, the medical department was rated as least important although this is available

Table 15

The Supervisor's Role in the Program
(Rank Order by Importance of Item)

Item	Employer							
	RPW	AGS	EDM	LAB	CNR	AGT	Total	No Answer*
Supervisor's responsibility is to:								
Face employee with his responsibility	1	2	1	1	1	1	1	2
Involve employee in treatment	2	1	3	2	3	3	2.5	1
Represent employer	4	3	2	3	2	2	2.5	1
Get the job done	3	5	4	4	4	5	4	12
Protect employee rights	5	4	5	5	5	4	5	14
Supervisor's prime resource is:								
His supervisor	1	1	1	1	1	1	1	3
Program counselor	2	2	3	5	3	4	2	18
Personnel officer	3	3	5	2	2	5	3.5	18
Company policy	4	5	2	4	4	3	3.5	14
Medical department	5	4	4	3	5	2	5	14
Supervisor helps employee most by:								
Showing personal concern	2	1	1	1	1	1	1	2
Good supervision	1	3	3	2	2	2	2	4
Offering professional referral	3	2	2	3	3	3	3	2
Firm discipline	4	4	4	4	4	4	4	10
Constructive coercion	5	5	5	5	5	5	5	14
Decision to refer should be made by:								
Immediate supervisor	2	1	1.5	1	1	1	1	12
Program counselor	1	2.5	1.5	2	2	3	2	11
Senior manager	3	2.5	3.5	4	3	2	3	12
Personnel officer	4	4	3.5	3	4	4	4	28
Union steward	5	5	5	5	5	5	5	41
Supervisor can refer most effectively:								
via Program counselor	1	1	1	2	1	3	1	11
via Manager or personnel	2	2	2	3	2	2	2	7
via Medical department	3	3	3	1	3	1	3	11
Directly	4	4	4	4	4	4	4	25
via Union representative	5	5	5	5	5	5	5	36

*See footnote Table 14.

in most of the programs.

Most programs state that the supervisor's concern should be limited to the employee's work performance. However, the supervisors indicated that they can be most helpful to problem employees by showing personal concern. Constructive coercion, however, was rated as least helpful.

The supervisors indicated that they should be responsible for the decision to refer a problem employee for diagnosis and/or treatment. The program counsellor and senior manager were next in order of importance. It is interesting to note that the personnel officer is not highly ranked although many programs rely very heavily on the personnel department to carry out this function. The union steward, who is frequently considered to have parallel responsibility with the supervisor in joint union/management programs, was ranked last and rejected outright by a large number of supervisors.

Although supervisors accepted responsibility for the decision to refer, they placed themselves ahead of only the union representative as the most effective implementers of the referral. The program counsellor was their first choice, followed by senior managers or personnel officers and the medical department.

PROGRAM COMPONENTS

This section includes data concerning the supervisors' reactions to statements concerning the program rationale, coordination of program elements and a number of generally accepted policy statements (Table 16). The supervisors were asked to indicate their agreement or disagreement with each statement on a five-point scale from strongly agree to strongly disagree. They were asked to avoid the middle ("Indifferent") column if possible. In order to simplify presentation of these findings, the "Agree" and "Strongly Agree" responses were combined and are presented by total percentage of supervisors agreeing with the statement. "Indifferent" responses were grouped with the minimal number of non-responses and are presented for the total group so that the total percentage of supervisors disagreeing with the statement can be inferred. The items in this section are grouped on

Table 16

Program Components
[by % agreeing (or strongly agreeing) with statements given]

Statements	Employer							Indifferent or No Answer*
	RPW	AGS	EDM	LAB	CNR	AGT	Total	
RATIONALE								
Need for program								
Incidence of behavioral health problems is significant	56.5	62.9	52.1	73.9	64.0	66.7	62.8	0.7
Behavioral health problems are costly	100.0	92.6	100.0	95.6	92.0	100.0	96.6	0.7
Employer has the right to implement behavioral health program	100.0	92.5	95.6	100.0	96.0	95.8	96.5	2.1
Most behavioral health problems are alcohol related	30.4	48.1	34.8	21.7	52.0	16.7	34.5	10.3
Work environment causes behavioral health problems	78.3	81.5	73.9	91.3	72.0	75.0	78.6	4.8
Motivation to accept treatment								
Threat of dismissal effectively motivates alcoholics	47.8	48.1	21.7	69.5	56.0	45.9	48.2	4.8
Threat of dismissal effectively motivates employees with other behavioral health problems	26.1	18.5	17.4	34.7	24.0	41.7	26.9	4.1
Most problem employees accept treatment voluntarily	34.8	48.1	43.5	13.0	32.0	29.2	33.8	3.4
Treatment effectiveness								
Treatment resolves behavioral health problems	69.5	85.2	65.2	82.6	72.0	87.5	77.3	12.4
Effective treatment restores work performance	69.5	96.3	82.6	78.3	92.0	91.6	85.5	10.3
Community treatment resources are readily available	65.2	81.5	56.5	78.3	76.0	70.8	71.7	7.6
COORDINATION OF PROGRAM ELEMENTS								
Union conflicts with program	21.7	18.5	8.7	78.2**	32.0	4.2	26.9	14.5
Union/management cooperation is needed	82.6	88.9	86.9	100.0	96.0	95.8	91.7	1.4
Senior management supports supervisor	78.2	96.3	69.6	73.9	80.0	95.9	82.7	10.4
Professional consultation is available	52.1	85.2	47.8	43.4	60.0	83.4	62.8	7.6
Treatment agency and work place should cooperate	100.0	96.3	100.0	100.0	92.0	95.8	97.3	2.1
Treatment agencies work with supervisors	52.2	81.5	43.5	47.8	56.0	66.7	58.6	25.5
Diagnostic and referral service is needed	90.3	92.6	100.0	91.3	96.0	95.8	94.5	4.1
PROGRAM POLICY								
Key statements								
Behavioral health problems are illnesses	91.3	100.0	86.9	95.7	96.0	95.9	94.4	2.1
Adequate benefits are provided	60.9	96.3	91.3	100.0	80.0	100.0	88.3	8.3
Problem employees should accept referral	69.5	96.3	82.6	82.6	80.0	70.8	80.7	4.8
Continued poor performance should result in discipline	82.6	66.6	78.2	82.6	100.0	91.7	83.5	3.5
Additional statements								
Program participation does not affect job security	73.9	77.7	78.3	78.2	88.0	75.0	78.6	4.1
Supervisor should be concerned only with work performance	30.4	18.5	4.3	34.7	24.0	4.2	19.3	0
Confidentiality is protected	52.2	88.9	56.5	82.6	84.0	91.6	76.5	13.1
Program limits personnel policy enforcement	4.3	18.5	17.3	39.1	40.0	16.7	22.8	15.2
Employee should seek help early	56.5	55.5	60.8	60.8	44.0	62.5	56.6	5.5
Supervisor's program training is adequate	0	22.2	13.0	34.8	16.0	41.7	21.4	4.8

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*Non-response was minimal–these percentages comprise primarily "indifferent" responses throughout.

**The assistance program was a strike issue in this company at the time of data collection.

the basis that they constitute an intermediate stage between the philosophical concept of the program and the practical process.

Program Rationale

The program rationale consists of arguments demonstrating the need for the program, the motivating power of the work place and the efficacy of treatment in resolving personal and work performance problems.

Need for Program The supervisors generally acknowledge the need for the program. There was almost unanimous agreement that behavioral health problems are costly and that the employer has a right to reduce these costs by implementing an assistance program. A majority of supervisors also agreed that a significant number of employees have behavioral health problems. In the follow-up interviews, it was noted that a number of supervisors who had disagreed with this statement estimated the prevalence of problem employees between 10–20%. Thus, some supervisors appear to have interpreted significance in a manner which reflects a high tolerance of problem employees.

The majority of supervisors did not agree that most behavioral health problems are alcohol-related. This corresponds to the low ranking of alcoholism as a cause of poor work performance in Table 14. It is noted that over three-quarters of the supervisors believe that the work environment often plays a part in causing behavioral health problems. This has important program implications in view of the lack of program strategies designed to correct problems in the work place as opposed to problems within the individual employee.

Motivation to Treatment Supervisors agreed (Table 15) that they have an obligation to face the employee with his own responsibility and to involve him in treatment. However, they did not consider constructive coercion as a helpful technique. These views are endorsed in the present section. Less than half the supervisors agreed that a threat of dismissal is effective in motivating alcoholic employees to accept treatment. Less than 30% believe that employees with other problems, such as mental illness, can be effectively motivated in this way. However, two-thirds of the respondents did not agree that most problem employees are willing to accept treatment voluntarily. This suggests that supervisors find themselves in a dilemma when they are required to motivate employees to accept treatment by using a technique in which they do not have confidence. The resulting frustration was expressed by a number of supervisors in the interview situation. The following quotations represent frequently stated sentiments.

> Any time you force a man to do something, I'm not too sure anybody wins . . . you can't force somebody into treatment if they don't want it.(Interview No. 1)

> Until they want to accept help there's nothing anybody can do. (Interview No. 18)

> They say, 'Alcoholics can't be helped by anyone, they must do it on their own.' I don't believe that. (Interview No. 11)

> We're all amateurs in handling people with this kind of problem . . . you know the guy's got a problem but your hands are tied–you can't do anything about it. (Interview No. 12)

The ambivalence of many supervisors is illustrated by the following remarks by supervisors with clearly divergent perspectives.

> You can't get people to do better by treating them progressively worse. (Interview No. 25)

> Lots of times you have to be a little harder on the person than you would be otherwise to get them to seek help for their own good–I know in my case if somebody had clamped down on me a little earlier I'd have probably gotten help before I did. (Interview No. 7)

A number of supervisors emphasized that constructive coercion should be used only as a last resort. However, very few were able to suggest an effective alternative. This resulted in considerable wishful thinking as illustrated by the supervisor who stated that he "would like to be able to suggest that he needs treatment and have him agree with me . . . I don't think it works out that way . . . I don't think suggestion is good enough." He concluded, "I don't have any way to motivate the employee that I am willing to use right now" (Interview No. 12). Many supervisors rationalized their lack of action. This is exemplified by one supervisor in discussing an alcoholic employee–"He's been around too long–we can't fire him. He's a good man . . . during the summer . . . when he's there" (Interview No. 17). When this supervisor was asked about the possibility of confronting the employee with the need for treatment, he burst out: "I couldn't say that to old George."[1]

Several supervisors expressed very well the pervasive sense of responsibility to provide a more positive alternative to coercive motivation. One recommended, "Don't force him–develop his sense of responsibility–respect him as a human being" (Interview No. 19). Another stated, "I got to make that guy go to the doctor because he wants to go to the doctor . . . I've got to convince him that that's the thing to do" (Interview No. 2). These statements reflect a strong emphasis by a large proportion of the interviewees that the problem employee's inner motivation must be developed.

Treatment Effectiveness A substantial majority of supervisors agreed that treatment is effective in resolving behavioral health problems and that when such problems are effectively treated, the employee's work performance usually returns to an acceptable level. They also agreed that treatment resources in the community are readily available and accessible to the problem employee. However, this strong endorsement of treatment effectiveness was subjected to a number of modifications concerning the program's utilization of treatment in the following section on the program process.

Follow-up interviews indicated that treatment was not considered a panacea for all work performance problems. A number of interviewees made it clear that they consider treatment inappropriate in many cases where poor work performance is not a result of behavioral health problems. One supervisor stated, "Work is work, it's not some kind of social program to help an individual" (Interview No. 6). Another suggested, "No amount of counselling would change that guy" (Interview No. 14). However, most of the supervisors interviewed appeared to feel a strong sense of responsibility and concern for employees whom they perceived as having legitimate problems. These made statements to the effect that "If you can help one person the program has paid for itself" (Interview No. 18). "A life is much more important than getting the job done" (Interview No. 7). "Anything that's gonna help toward a better, more stable employee is good for the company as a whole" (Interview No. 6).

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[1] Not his real name.

In summary, the supervisors appear to agree with the program rationale at a general level except for the assumption that alcoholism is a primary problem and the emphasis on coercive motivational methods. Substantial intergroup differences of opinion were noted with regard to the prevalence of alcoholism and the need for, and effectiveness of, constructive coercion.

Coordination of Program Elements

Several questions were directed at the relationships among the union, supervisory resources in the work place and treatment agencies in the community as these affect the program.

The need for union/management cooperation was strongly endorsed and few supervisors perceived the union's role as conflicting with the program. The one exception was a group of supervisors whose employees were engaged in a strike which involved a dispute over program issues.

Most supervisors agreed that they have adequate support from senior management in utilizing the assistance program and a small majority indicated that adequate consultation was available from a qualified professional when they were faced with a difficult employee problem. However, the term "adequate consultation" appeared to be interpreted rather loosely. In the interviews, several supervisors explained that they had agreed with the statement because they had access to a senior manager, a safety officer, a telephone "distress line" or a variety of potential and somewhat nebulous resources in cases of extreme difficulty.

There was almost unanimous agreement that the problem employee's rehabilitation program should involve cooperation between the treatment agency and the work place. However, only a small majority agreed that treatment agencies work closely with the supervisor to help problem employees, i.e., obtain relevant information from the supervisor and give him useful feedback. There was strong agreement among all groups that an effective assistance program needs to provide diagnostic and referral services as a link between the work place and the treatment agency. Thus, it seems apparent that supervisors recognize their own need for coordination with the treatment agency but do not appreciate the possibility that they may serve as a valuable resource to the treatment agency in enhancing treatment effectiveness (see Table 14). A number of supervisors expressed some confusion in the interviews about their relationship with the treatment agency.

One supervisor, in considering referral of problem employees for assessment, noted "If I don't know why they're not doing well, I really can't say, 'Well, I don't think you're doing well, so you had better go ask somebody why I don't think you're doing well'" (Interview No. 6). The same supervisor suggested that a program counsellor might be helpful in expediting the referral by confirming the appropriateness of this course of action. "I keep thinking . . . maybe he's fine and it's me that's crazy."

Policy Statements

A number of policy statements which have been adopted by a large number of programs were selected from the literature. The first four have been described as the key policy statements in the program. Supervisors were asked to indicate if they agree with the statements. (The converse of several statements was included to preclude a positive "set" on the part of the supervisors.)

The supervisors strongly endorsed the key policy statements. They agreed that behavioral health problems, such as alcoholism, are illnesses; that adequate sickness benefits are provided for employees with behavioral health problems; that the supervisor has a right to expect problem employees to accept referral for diagnosis and treatment; and that failure to overcome poor work performance should result in discipline or dismissal. A substantial majority also agreed that the employee's rights are adequately protected. Specifically, they agreed that the employee can be guaranteed that cooperation with the program will not affect his job security or opportunities for advancement and the program adequately protects the employee's confidentiality. Considerable variation was noted among groups, however, concerning the issue of confidentiality. A majority of supervisors also believe that the program does not limit their right to enforce standard personnel policy.

A large majority of supervisors rejected the idea that they should be concerned only with the work performance of the problem employee. This supports the findings presented in Table 15 that supervisors believe they can help employees most by showing personal concern and are not primarily responsible for simply "getting the job done." A small majority of supervisors also agreed that it is the employee's responsibility to seek help on his own when he first develops a behavioral health problem. A number of supervisors who disagreed with this statement were asked for clarification in the interview. The most typical response was that problem employees are often unaware that they have a problem and can, therefore, not be expected to initiate corrective action on their own.

Many policies state that the employer accepts responsibility for providing adequate training to supervisors with regard to the program. However, a large majority of supervisors did not agree that adequate training is provided. This is reflected in the findings reported in Table 8 that only about one-quarter of the supervisors are confident of their knowledge of how to use the program. It is noted that satisfaction with the training program varied widely among employer groups. This suggests that, although none of the training programs are considered adequate, some are significantly superior to others.

PROGRAM PROCESS

The program process is most frequently described in three stages; identification of problem employees, motivation of these employees to resolve their problem and referral to a treatment resource. Identification and motivation are the steps most strongly emphasized in the literature.

Identification of Problem Employees

The concept of employee assistance programming relies heavily on a) tne assumption that poor work performance is indicative of an underlying behavioral health problem, b) the supervisor's ability to recognize poor work performance, and c) the supervisor's willingness to involve the employee in the program.

Over two-thirds of the supervisors (Table 17) agreed that poor work performance is a reliable sign of underlying behavioral health problems. However, less than one-half agreed that employees who are not performing adequately on the job usually have behavioral health problems. When this discrepancy was brought to the attention of supervisors in the interview situation, they explained that they had interpreted the first statement to mean that when an employee has a behavioral health problem, there is a high probability that his work performance will be affected. However, of all employees who are performing poorly, they anticipate that a minority would have underlying behavioral health problems. It would appear, therefore, that these supervisors do not in fact support the basic premise that work performance problems reliably indicate the presence of underlying behavioral health problems.

A majority of supervisors agreed that existing performance standards are fair and clear. However, there was considerable variation among subgroups on this point. A majority of supervisors believe that many incidents of poor work performance can best be handled without documentation. It is noted that formal documentation is considered a crucial step in identifying problem employees and preparing to confront them. Therefore, the response to this item strongly suggests that a large number of supervisors are not committed to utilization of the program in many instances, but prefer to deal with problems informally. The program's strong reliance on formal action is, therefore, not compatible with current practice.

The supervisors strongly agreed that they are in the best position to identify employees who may have behavioral health problems and that they are contributing to the

Table 17

Program Process
[by % agreeing (or strongly agreeing) with statements given]

Statements	RPW	AGS	Employer EDM	LAB	CNR	AGT	Total	Indifferent or No Answer*
Identification								
Poor performance indicates a behavioral health problem	50.8	74.1	60.8	82.6	76.0	62.5	69.7	9.0
Most poor performers have behavioral health problems	47.8	40.7	47.8	47.8	40.0	54.2	46.2	4.1
Performance standards are fair and clear	69.5	81.5	60.9	56.5	76.0	79.2	71.0	5.5
Poor performance often need not be documented	78.2	63.0	65.2	56.5	64.0	50.0	62.8	2.1
Supervisor is best identifier of employees with behavioral health problems	82.6	88.9	82.6	100.0	88.0	95.9	89.6	2.8
Supervisor's failure to identify problem employee contributes to the problem	95.6	96.3	85.7	95.7	96.0	95.8	95.9	0.7
Supervisor usually knows *why* an employee performs poorly	21.7	40.7	26.1	39.1	36.0	50.0	35.9	5.5
Identification is in employee's best interests	91.3	92.6	95.6	87.0	72.0	83.4	86.9	3.5
Identification should occur early	95.6	100.0	100.0	100.0	100.0	100.0	99.3	0.0
Program involvement is in employee's best interests	86.9	100.0	95.7	95.7	96.0	95.8	95.2	4.1
Referral								
Supervisor can select appropriate treatment agency	4.3	14.8	13.0	13.0	24.0	16.7	14.5	9.7
Coordination between treatment and work is important	95.6	92.6	100.0	95.6	92.0	95.8	95.1	2.1
Supervisor has adequate input to treatment agency	21.7	44.4	17.4	34.8	24.0	58.4	33.8	22.1
Supervisor receives adequate feedback from treatment agency	17.3	37.0	39.1	34.8	28.0	75.0	38.7	30.4
Many problems resolve themselves without treatment	26.1	25.9	43.4	8.7	28.0	54.1	31.1	6.2
Coercion reduces treatment effectiveness	47.8	22.2	43.4	47.8	44.0	62.5	44.1	9.7
Motivation								
Supervisor has coercive authority	60.9	51.8	43.5	30.4	20.0	66.7	45.5	5.5
Coercion is part of supervisor's job	56.5	55.5	30.4	60.8	40.0	75.0	53.1	10.4
Coercion is in employee's best interests	43.4	59.3	52.1	65.2	60.0	54.2	55.9	10.4
Coercion may disrupt supervisor/employee relationship	39.1	37.0	47.8	69.6	40.0	58.3	48.3	6.9
Senior management supports the supervisor in a grievance	73.9	88.9	69.5	56.5	60.0	87.5	72.1	9.7
Coercion may harm the employee	69.5	37.0	60.9	39.1	48.0	62.5	52.5	6.2

*Non-response was minimal—these percentages comprise primarily "indifferent" responses throughout.

employee's problem if they fail to identify and confront the problem employee. Thus, they appear to accept their role in the program as a moral obligation. This was confirmed by a number of supervisors in the interviews. A large majority also agreed that identification of problem employees is always in the employee's best interests and that problem employees should be identified at the earliest possible stage. Most of the supervisors further agreed that involvement in the assistance program is in the best interests of the problem employee. It would appear from these responses that the supervisors endorse the program for employees whom they perceive as "troubled" but do not necessarily equate poor work performance with the existence of behavioral health problems. A majority of supervisors indicated that they usually do not know why an employee is performing poorly on the job.

In the follow-up interviews, most supervisors displayed a rather low level of awareness of the nature of behavioral health problems or their significance in relation to work performance or treatment requirements. There was a strong tendency to describe the employee's underlying problem in terms of social/environmental pressures or attitudinal factors. The second category of employee problems was described in terms of work pressures, such as shift work and travel requirements, or unsuitability of the employee for the job. A large number of interviewees noted that their decision to utilize the program depended on their ability to diagnose the employee's underlying problem in order to ensure that program utilization was appropriate. This suggests that the program has failed to operationalize its premise that treatment is appropriate in dealing with poor performance.

In most of the examples cited by the supervisors, they had been aware of an ongoing problem for a period of several years before taking corrective action. In many cases, the supervisors stated that they had attempted to counsel the employee and implied that one of their goals was to avoid the need for confrontation. The findings in this section suggest that supervisors are aware of a significant number of problem employees but, because they do not see a strong connection between poor performance and behavioral health problems, they are often reluctant to utilize the program. The program obviously does not adequately meet the needs of the supervisor a) in determining how to handle a performance problem initially, or b) in helping him to perceive the needs of the problem employee in a behavioral health context. One supervisor summed up his feelings by saying, "When it comes to behavioral problems with an employee–that's beyond my capacity as a supervisor" (Interview No. 11).

Motivation of Problem Employees

Historically, the *raison d'etre* of employee assistance programs has been the contention that the work place provides a unique set of circumstances which can be utilized to motivate individuals with debilitating problems to accept treatment and, consequently, restore their ability to function effectively. However, less than one-half of the supervisors agreed that they have the necessary authority to motivate most problem employees to accept treatment through the use of constructive coercion. Slightly over one-half agreed that constructive coercion is a proper part of their job and is in the best interests of the problem employee. Almost one-half agreed that the use of constructive coercion is likely to disrupt the working relationship between the supervisor and the employee. Just over one-half believe that constructive coercion carries the risk that the employee will be harmed rather than helped. These responses appear to reflect strong ambivalence with regard to constructive coercion as well as sharp differences of opinion. For this section the only item which was endorsed by a substantial majority of supervisors stated that senior management will support the supervisor if the employee disputes or grieves his action.

As noted in the section on program rationale, many of the supervisors who were interviewed expressed the conviction that the employee must be internally motivated rather than simply forced to comply with the supervisor's demands. Many implied that constructive coercion negates the employee's dignity and right to self determination. A combination of factors was mentioned by supervisors with regard to their reluctance to use coercive techniques. They suggested that constructive coercion may very well harm, rather than help, the employee. This concern is supported by research findings (Bergin, 1971) that even treatment is not benign. The supervisors also perceived a significant risk to themselves in terms of their managerial credibility and their relationship to the employee. A number implied that they felt responsible to resolve performance problems without having to admit the need for outside help. They did not appreciate the potential value of treatment or the implications of behavioral health problems for work performance. A number of supervisors also indicated that the union's influence in the work place severely limited their ability to apply coercion, even if they chose to do so. Thus, constructive coercion appears to be viewed as a risky, somewhat unethical and frequently ineffective strategy for meeting the employer's goals with little benefit for the employee or the supervisor. It is not surprising, therefore, that supervisors expressed a strong need for support in carrying out their functions within the program.

Referral for Treatment

Only 14.5% of the supervisors agreed with the suggestion that they are in a position to select an appropriate treatment agency for the problem employee. However, almost all of the supervisors agreed that coordination between the work place and the treatment agency is important. This coordination is currently considered to be adequate by a definite minority of supervisors in terms of both the input they have to the treatment agency and the feedback they receive. Most supervisors disagreed that many problems tend to resolve themselves without treatment. Consequently, the need for coordination between treatment agency and work place is an important issue for supervisors and requires much further attention. It is noted that less than half the supervisors agreed that the effectiveness of treatment is reduced in cases where the client has been coerced to accept treatment. The implication seems to be that supervisors have serious questions about their own role in the program process rather than about the value of treatment itself.

The need for an effective program is clearly demonstrated from the supervisor's point of view but it is equally clear that the program, as the supervisors currently see it, is seriously inadequate. Thus, the premise of this study has been supported by the findings for the total sample. In the following section a comparison is made between various categories of supervisors in an effort to identify factors which contribute to the success or failure of employee assistance programs.

FINDINGS BY COMPARISON GROUPS

In this section comparisons are made between supervisors who differ on several characteristics which are thought to correlate with differences in program perception and utilization. Comparisons are presented by age, sex, knowledge of the program, managerial affiliation and administrative level of position.

Data from the major sections in the questionnaire are presented in a format similar to that used in the preceding section. Demographic data and information on program utilization are summarized briefly.

COMPARISON BY AGE

The entire sample group was categorized by age. Supervisors below forty years of age are compared with supervisors aged 40 and over.

DEMOGRAPHIC DATA (Table 18)

The older group comprised slightly over half the total group of supervisors. As expected, the older supervisors had more experience as supervisors and more seniority with their employer than did the younger group. A small majority in both groups described themselves as managers with no union affiliation. However, the older group included a somewhat larger percentage of senior supervisors, i.e., those who supervise employees who, in turn, have supervisory responsibilities. A smaller percentage of younger supervisors were confident that they knew how to use the program in comparison to older supervisors.

PROGRAM UTILIZATION (Table 19)

The older group had supervised a slightly larger number of employees during the past year. Their rate of identification of problem employees was more than 50% above that of the younger supervisors. However, this higher rate of identification was achieved by a proportionately smaller percentage of the entire subgroup of supervisors.

Table 18

Demographic Data

Comparison by Age

	<40	≥40
	Mean	Mean
Average years in supervisory position	6.7	13.5
Average years with present employer	9.8	18.1
	Percent	Percent
Percent of total group classified by age	44.8	55.2
Percent who are managers–no union affiliation	58.5	58.8
Percent who are senior supervisors	44.2	57.9
Percent who know how to use program	20.0	32.5
Percent who know how to use program –at least to some extent	67.7	80.0
	N=65	N=80

Table 19

Program Utilization

Comparison by Age

	< 40	⩾ 40
	N=145	
	Mean	Mean
Average number of employees supervised in past year	33.7	36.5
Average number of problem employees recognized	3.4	5.3
	Percent	Percent
Percent of supervisors who reported having problem employees	64.6	50.0
Percent of employees considered to be "problems"	10.1	14.5
Percent of problem employees* who were:		
–offered voluntary referral	6.4	6.3
–"constructively coerced"	10.1	11.7
Percent of supervisors with problem employees		
–who offered voluntary referral	23.8	32.5
–who used constructive coercion	19.0	30.0

*From Table 11–includes all such actions, not the most intensive action only.

Thus, the older supervisors vary widely in their recognition of problem employees.

Both age groups offered voluntary referral to a similar percentage of problem employees but utilized constructive coercion more frequently, with the older supervisors utilizing this technique slightly more than did the younger group. In both groups the above techniques were utilized by a minority of supervisors who had problem employees although a larger percentage of the older supervisors did so.

These findings support, in part, the conclusions of Roman and Trice (1976) that younger, less experienced supervisors are the poorest program implementers. However, the results summarized above suggest that some of the older supervisors have a distinctively high rate of program utilization which is not generalized to the entire group. The following comparisons are presented as a means of determining whether younger supervisors differ from older ones in their perception of the program.

PROGRAM PHILOSOPHY

Table 20 shows no significant differences between the two age groups in their perception of the program's purpose. However, the older supervisors appear to consider the work situation slightly less important as a factor causing poor performance than do the younger supervisors. The major philosophical difference between the two groups relates to their perception of the source of the problem employee's motivation to accept treatment. The younger supervisors considered confrontation by the supervisor a more important source of motivation than did the older supervisors. It has been noted, however, that they did not utilize this technique as often.

ROLE OF THE SUPERVISOR (Table 21)

The supervisor's role was also viewed similarly by both groups. The primary differences related to their perception of their own resources in the program. The younger group considered the personnel officer and the medical department more important and the program counsellor less important in comparison with the older supervisor group.

Table 20

Program Philosophy

Comparison by Age
(Rank Order by Importance of Item)

Item	Age	
	<40	≥40
PURPOSE OF PROGRAM		
Program Purpose is to:		
Assist employees	1	1
Assist supervisors	2	2
Improve organization	3	3
Reduce illness	5	4
Save money	4	5
Program Benefits:		
Employee	1	1
Employer	2	2
Supervisor	3	3
Society	4	4
Union	5	5
PROGRAM CONCEPT		
Poor Work Performance is Due to:		
Other behavioral health problems	1	1
Work situation	2	3.5 *
Lack of ability/training	3	2
Alcoholism	4	3.5
Inappropriate management	5	5
Source of Motivation:		
Personal responsibility	2	1
Family & social pressure	2	2
Situational crises	4	3
Confrontation by supervisor	2	5 *
Professional/medical information	5	4
Treatment Effectiveness Depends On:		
Attendance by employee	1	1
Appropriateness	2	2
Accessibility	3	3
Quality of service	4	4
Coordination with work place	5	5

Note: Order of items reflects rank order for total group (see Table 14).

Table 21

The Supervisor's Role in the Program

Comparison by Age
(Rank Order by Importance of Item)

Item	<40	>40
Supervisor's responsibility is to:		
Face employee with his responsibility	1	1
Involve employee in treatment	3	2
Represent employer	2	3
Get the job done	4	4
Protect employee rights	5	5
Supervisor's prime resource is:		
His supervisor	1	1
Program counselor	2	5☆
Personnel officer	4	2☆
Company policy	3	3.5
Medical department	5	3.5☆
Supervisor helps employee most by:		
Showing personal concern	1	1
Good supervision	2	2
Offering professional referral	3	3
Firm discipline	4	4
Constructive coercion	5	5
Decision to refer should be made by:		
Immediate supervisor	1	1
Program counselor	2	2
Senior manager	3	3
Personnel officer	4	4
Union steward	5	5
Supervisor can refer most effectively:		
via Program counselor	1	1.5
via Manager or personnel	2	3
via Medical department	3	1.5☆
Directly	4	4
via Union representative	5	5

Note: Order of items reflects rank order for total group (see Table 14).
☆Rank order difference > 1.

Consequently, the younger group was somewhat more inclined to initiate referrals through the medical department.

PROGRAM COMPONENTS

Data comparing the two age groups' views on the program rationale, coordination of program elements and program policy are presented in Table 22. Throughout this section, the views of the two groups are very similar. Thus, it would appear that age difference is not an important factor in supervisors' perception of these program components.

PROGRAM PROCESS

The two groups also had very similar views on the identification, motivation and referral of problem employees (Table 23). Consequently, it would appear that very few differences in the supevisors' attitudes and opinions concerning the program are associated with age. Seniority and supervisory experience also do not appear to affect the supervisors' view of the program, as these factors are positively correlated with age.

COMPARISON BY SEX

Program design and research has been directed almost exclusively toward males. However, a number of concerns have been expressed recently that female employees may require a somewhat different program approach than do males. Therefore it was considered important to compare the responses of female supervisors to those of males.

Unfortunately, females comprised a relatively small proportion of the total sample group. Consequently, this set of comparisons should be viewed as very tentative.

DEMOGRAPHIC DATA

Female supervisors had been employed almost as long as males but had been supervisors for a much shorter period of time (Table 24). A similar percentage of male and female supervisors identified themselves as managers with no union affiliation, although a substantially higher proportion of females were in senior supervisory positions. A similar number of males and females had at least some knowledge of how to use the program.

Table 22

Program Components

Comparison by Age
(mean response to statements given)

Statements	Age <40	Age ≥40
RATIONALE		
Need for program		
Incidence of behavioral health problems is significant	2.7	2.7
Behavioral health problems are costly	1.7	1.6
Employer has the right to implement behavioral health program	1.7	1.5
Most behavioral health problems are alcohol related	3.2	3.2
Work environment causes behavioral health problems	2.2	2.3
Motivation to accept treatment		
Threat of dismissal effectively motivates alcoholics	3.2	2.9
Threat of dismissal effectively motivates employees with other behavioral health problems	3.6	3.6
Most problem employees accept treatment voluntarily	3.5	3.3
Treatment effectiveness		
Treatment resolves behavioral health problems	2.3	2.2
Effective treatment restores work performance	2.1	2.1
Community treatment resources are readily available	2.5	2.3
COORDINATION OF PROGRAM ELEMENTS		
Union conflicts with program	3.3	3.4
Union/management cooperation is needed	1.7	1.8
Senior management supports supervisor	2.3	1.9
Professional consultation is available	2.8	2.4
Treatment agency and work place should cooperate	1.7	1.8
Treatment agencies work with supervisors	2.5	2.5
Diagnostic and referral service is needed	1.9	1.8
PROGRAM POLICY		
Key statements		
Behavioral health problems are illnesses	1.5	1.6
Adequate benefits are provided	2.0	1.8
Problem employees should accept referral	2.3	2.0
Continued poor performance should result in discipline	2.0	2.0
Additional statements		
Program participation does not affect job security	2.2	2.1
Supervisor should be concerned only with work performance	3.7	3.9
Confidentiality is protected	2.2	2.2
Program limits personnel policy enforcement	3.4	3.4
Employee should seek help early	3.0	2.6
Supervisor's program training is adequate	3.8	3.6

Table 23

Program Process

Comparison by Age
(mean response to statements given)

Statements	< 40	⩾ 40
Identification		
Poor performance indicates a behavioral health problem	2.5	2.4
Most poor performers have behavioral health problems	3.2	2.9
Performance standards are fair and clear	2.6	2.4
Poor performance often need not be documented	2.6	2.8
Supervisor is best identifier of employees with behavioral health problems	1.9	2.0
Supervisor's failure to identify problem employee contributes to the problem	1.8	1.7
Supervisor usually knows *why* an employee performs poorly	3.3	3.3
Identification is in employee's best interests	2.1	2.1
Identification should occur early	1.7	1.6
Program involvement is in employee's best interests	1.8	1.7
Motivation		
Supervisor has coercive authority	3.2	3.1
Coercion is part of supervisor's job	2.9	2.9
Coercion is in employee's best interests	2.8	2.7
Coercion may disrupt supervisor/employee relationship	3.0	2.9
Senior management supports the supervisor in a grievance	2.4	2.3
Coercion may harm the employee	2.8	3.0
Referral		
Supervisor can select appropriate treatment agency	3.8	3.7
Coordination between treatment and work is important	1.9	2.0
Supervisor has adequate input to treatment agency	3.3	3.0
Supervisor receives adequate feedback from treatment agency	2.9	3.0
Many problems resolve themselves without treatment	3.4	3.5
Coercion reduces treatment effectiveness	3.0	3.1

Table 24

Demographic Data

Comparison by Sex

	Males	Females
	N = 145	
	Mean	Mean
Average years in supervisory position	11.0	6.2
Average years with present employer	14.5	13.5
	Percent	Percent
Percent of total group classified by sex	87.6	12.4
Percent with exclusively management affiliation	58.3	61.1
Percent in senior supervisory positions	48.8	72.2
Percent who know how to use the program —at least to some extent	74.8	72.2
Percent who know how to use the program —definitely	29.1	11.1

However, a much higher percentage of males stated with confidence that they knew how to use the program.

PROGRAM UTILIZATION

Table 25 shows that males supervised more than twice as many employees in the past year, as did females. However, this difference appears to be accounted for by one, all-male, employer group which uses team management in a shift work situation (see Table 10). Accordingly, it may be concluded that females are responsible for a similar number of employees as are most male supervisors.

The two groups were very similar in percent of supervisors who reported having problem employees and percent of employees identified as problems. Both groups offered voluntary referral to employees at a similar rate but male supervisors utilized constructive coercion in a much higher percentage of cases. Both of these actions were utilized by more male than female supervisors.

PROGRAM PHILOSOPHY

Almost complete agreement was noted between males and females with regard to the program's purpose (Table 26). Their views were also similar concerning the program's concept except for a difference of opinion concerning motivation. Females rated confrontation by the supervisor as less important than did males. However, the females considered situational crises as relatively more important sources of motivation.

ROLE OF THE SUPERVISOR

Table 27 compares the opinions of male and female supervisors with regard to their own role in the program. Females relied much less on company policy and more on the medical department as a resource to themselves, as compared with male supervisors. Females also considered the medical department as more important in initiating referrals.

Table 25

Program Utilization

Comparison by Sex

	Males	Females
	Mean	Mean
Average number of employees supervised in past year	38.0	16.2
Average number of problem employees recognized	4.8	1.8
	Percent	Percent
Percent of supervisors who reported having problem employees	56.7	55.6
Percent of employees considered to be "problems"	12.7	11.0
Percent of problem employees* who were:		
–offered voluntary referral	6.4	6.3
–"constructively coerced"	11.6	3.0
Percent of supervisors with problem employees		
–who offered voluntary referral	27.8	20.0
–who used constructive coercion	23.6	10.0
	N=127	N=18

*From Table 11.

Table 26

Program Philosophy

Comparison by Sex
(Rank Order by Importance of Item)

Item	Male	Female
PURPOSE OF PROGRAM		
Program Purpose is to:		
Assist employees	1	1
Assist supervisors	2	3
Improve organization	3	2
Reduce illness	4	4
Save money	5	5
Program Benefits:		
Employee	1	1
Employer	2	2
Supervisor	3	3
Society	4	4
Union	5	5
PROGRAM CONCEPT		
Poor Work Performance is Due to:		
Other behavioral health problems	1	1
Work situation	2.5	2
Lack of ability/training	2.5	3
Alcoholism	4	5
Inappropriate management	5	4
Source of Motivation:		
Personal responsibility	1.5	1
Family & social pressure	1.5	3☆
Situational crises	4	2☆
Confrontation by supervisor	3	5☆
Professional/medical information	5	4
Treatment Effectiveness Depends On:		
Attendance by employee	1	1
Appropriateness	2	2
Accessibility	3	3.5
Quality of service	4	3.5
Coordination with work place	5	5

Note: Order of items reflects rank order for total group (see Table 14).
☆Rank order difference > 1.

Table 27

The Supervisor's Role in the Program

Comparison by Sex
(Rank Order by Importance of Item)

Item	Male	Female
Supervisor's responsibility is to:		
Face employee with his responsibility	1	1
Involve employee in treatment	2.5	2
Represent employer	2.5	3
Get the job done	4	[illegible]
Protect employee rights	5	4
Supervisor's prime resource is:		
His supervisor	1	1
Program counselor	2.5	2
Personnel officer	4	4
Company policy	2.5	5★
Medical department	5	3☆
Supervisor helps employee most by:		
Showing personal concern	1	2
Good supervision	2	1
Offering professional referral	3	3
Firm discipline	4	4
Constructive coercion	5	5
Decision to refer should be made by:		
Immediate supervisor	1	1
Program counselor	2	2
Senior manager	3	3
Personnel officer	4	4
Union steward	5	5
Supervisor can refer most effectively:		
via Program counselor	1	2
via Manager or personnel	2	3
via Medical department	3	1★
Directly	4	4
via Union representative	5	5

Note: Order of items reflects rank order for total group (see Table 14).
☆Rank order difference > 1.
★Rank order difference > 1 and mean difference > .5.

PROGRAM COMPONENTS (Table 28)

Female supervisors disagreed more strongly than did males with the statement that most behavioral health problems are alcohol related. They also disagreed more strongly with the statement that most problem employees are willing to accept treatment voluntarily. However, they were more satisfied with the provision of professional consultation. Their views on the policy were very similar to those expressed by male supervisors.

PROGRAM PROCESS

Males and females had very similar views on the process of identification, motivation and referral of problem employees (Table 29). Females felt more strongly that constructive coercion is not in the best interests of the problem employee and were more in favor of the statement that many problems tend to resolve themselves without treatment.

The above comparisons suggest that the sex of the supervisor is not associated with very many differences in perspective regarding the program. However, female supervisors appear to be much less inclined to use constructive coercion.

COMPARISON BY KNOWLEDGE OF PROGRAM

Supervisors were asked if they knew how to use their employer's employee assistance program. They were then categorized as those who knew how to use the program, those who did not know how, and those who knew how to use the program to some extent. The latter category comprised almost one-half of the sample, whereas the first two categories each contained approximately one-quarter of the supervisors.

Throughout most of the literature on the program the assumption is made that program utilization by supervisors is strongly correlated with the amount and quality of training they receive. If this assumption is valid, the supervisors in this study who know the program should be expected to report significantly higher program use and more positive perceptions of the program than do the other groups.

Table 28

Program Components

Comparison by Sex
(mean response to statements given)

Statements	Male	Female
RATIONALE		
Need for program		
Incidence of behavioral health problems is significant	2.7	2.8
Behavioral health problems are costly	1.7	1.5
Employer has the right to implement behavioral health program	1.6	1.7
Most behavioral health problems are alcohol related	3.1	3.7†
Work environment causes behavioral health problems	2.2	2.2
Motivation to accept treatment		
Threat of dismissal effectively motivates alcoholics	3.0	3.1
Threat of dismissal effectively motivates employees with other behavioral health problems	3.6	3.6
Most problem employees accept treatment voluntarily	3.3	3.8†
Treatment effectiveness		
Treatment resolves behavioral health problems	2.3	2.2
Effective treatment restores work performance	2.1	2.0
Community treatment resources are readily available	2.4	2.4
COORDINATION OF PROGRAM ELEMENTS		
Union conflicts with program	3.3	3.7
Union/management cooperation is needed	1.8	1.7
Senior management supports supervisor	2.1	1.9
Professional consultation is available	2.6	2.1†
Treatment agency and work place should cooperate	1.8	1.5
Treatment agencies work with supervisors	2.5	2.4
Diagnostic and referral service is needed	1.8	1.7
PROGRAM POLICY		
Key statements		
Behavioral health problems are illnesses	1.6	1.5
Adequate benefits are provided	1.9	1.7
Problem employees should accept referral	2.1	2.2
Continued poor performance should result in discipline	2.0	1.8
Additional statements		
Program participation does not affect job security	2.2	2.0
Supervisor should be concerned only with work performance	3.8	3.6
Confidentiality is protected	2.2	1.8
Program limits personnel policy enforcement	3.4	3.8
Employee should seek help early	2.8	2.6
Supervisor's program training is adequate	3.7	3.4

†Mean difference ≥ .5.

Table 29

Program Process

Comparison by Sex
(mean response to statements given)

Statements	Male	Female
Identification		
Poor performance indicates a behavioral health problem	2.5	2.2
Most poor performers have behavioral health problems	3.0	3.1
Performance standards are fair and clear	2.5	2.2
Poor performance often need not be documented	2.7	2.8
Supervisor is best identifier of employees with behavioral health problems	2.0	1.9
Supervisor's failure to identify problem employee contributes to the problem	1.7	1.7
Supervisor usually knows *why* an employee performs poorly	3.2	3.6
Identification is in employee's best interests	2.1	2.1
Identification should occur early	1.7	1.6
Program involvement is in employee's best interests	1.7	1.8
Motivation		
Supervisor has coercive authority	3.2	2.8
Coercion is part of supervisor's job	2.8	3.1
Coercion is in employee's best interests	2.7	3.3[†]
Coercion may disrupt supervisor/employee relationship	3.0	2.8
Senior management supports the supervisor in a grievance	2.4	2.0
Coercion may harm the employee	2.9	2.7
Referral		
Supervisor can select appropriate treatment agency	3.8	3.5
Coordination between treatment and work is important	1.9	1.8
Supervisor has adequate input to treatment agency	3.2	2.8
Supervisor receives adequate feedback from treatment agency	3.0	2.7
Many problems resolve themselves without treatment	3.5	2.9[†]
Coercion reduces treatment effectiveness	3.1	2.6

[†] **Mean difference ≥ .5.**

DEMOGRAPHIC COMPARISON

Table 30 shows that supervisors who knew how to use the program differed very little from the other groups in length of supervisory experience and had only slightly more seniority than did the moderately knowledgeable supervisors.

Program knowledge appeared to be strongly correlated with holding a management, as opposed to a union, position. A large majority of those who knew how to use the program identified themselves as managers whereas a small percentage of those who did not know, were managers. The knowledgeable group also contained a disproportionately high percentage of senior supervisors.

The conclusion that program knowledge is not evenly distributed among supervisors was supported by the data in Table 31. This table summarizes the supervisors' source of knowledge about the program. The knowledgeable group had more frequently received information from formal sources such as training programs and literature. The moderately knowledgeable group had more frequently heard about the program indirectly.

The results in this table substantiate the validity of the supervisors' indication of their level of knowledge about the program. In addition, it is noted that only 12.4% of the total group had received no information about the program. Accordingly, it would appear that this study is based on a relatively knowledgeable sample group.

PROGRAM UTILIZATION (Table 32)

Wide variation is noted among the three sub-groups in the number of employees supervised by them. It is noted that the knowledgeable group is close to the mean for the total group whereas the supervisors who do not know how to use the program have supervised relatively few employees. This may reflect decreased relevance of the program to supervisors with few employees.

Knowledge of the program does not, however, appear to be associated with program utilization. The knowledgeable supervisors identified the smallest percentage of problem employees, compared to the highest percentage by the unknowledgeable group.

Table 30

Demographic Data

Comparison by Knowledge of Program

	Know	Don't Know	Know to Some Extent
	N = 141		
	Mean	Mean	Mean
Average years in supervisory position	11.2	10.7	10.0
Average years with present employer	16.9	10.6	15.1
	Percent	Percent	Percent
Percent of total group who know how to use the program	26.9	22.8	47.6
Percent who identify themselves exclusively as managers	87.2	18.2	65.2
Percent in senior supervisory positions	74.1	42.1	47.0

Table 31

How Program Knowledge Was Obtained

Source of Information	Know	Don't Know	Know to Some Extent
	Utilization of Information Sources by Percent of Supervisors		
Attended regular training session	17.9	3.0	14.5
Special seminar or workshop	38.5	0.0	23.2
Read detailed program description	35.9	0.0	11.6
Received copy of the policy	66.7	6.1	36.2
By using it	20.5	0.0	14.5
Personal consultation (from senior manager or program staff	25.6	0.0	24.6
Heard about it indirectly	15.4	15.2	33.3
Received no information	0.0	54.5	0.0
Average rate of utilization of information sources	31.5	3.5	22.6
	N=39	N=33	N=69

Table 32

Program Utilization

Comparison by Knowledge of Program

	Know	Don't Know	Know to Some Extent
	Mean	Mean	Mean
Average number of employees supervised in past year	29.4	10.3	52.5
Average number of problem employees recognized	3.3	1.6	6.7
	Percent	Percent	Percent
Percent of supervisors who reported having problem employees	45.9	57.6	66.7
Percent of employees considered to be "problems"	11.2	15.3	12.8
Percent of problem employees* who were:			
–offered voluntary referral	7.8	9.3	5.6
–"constructively coerced"	3.9	14.8	12.7
Percent of supervisors with problem employees			
–who offered voluntary referral	41.2	15.8	28.3
–who used constructive coercion	17.6	10.5	32.6

*From Table 11.

The knowledgeable supervisors utilized constructive coercion with a much smaller percentage of employees than did the other two groups. Voluntary referral was offered slightly less often by knowledgeable supervisors than by those who do not know how to use the program. The percentage of supervisors in each group who used constructive coercion was much smaller among the knowledgeable supervisors than among the supevisors who had some knowledge of the program. However, knowledgeable supervisors indicated more widespread use of voluntary referral.

PROGRAM PHILOSOPHY

No major differences were noted in the supervisor's views concerning the program's purpose (Table 33). However, the most knowledgeable group differed sharply from the least knowledgeable group on several issues concerning motivation of problem employees. The knowledgeable supervisors ranked confrontation by the supervisor as the primary source of motivation whereas the least knowledgeable group ranked this item lowest. The moderately knowledgeable group was at the mid-point between these views. However, the employee's personal responsibility to accept treatment was ranked lowest by the knowledgeable group and highest by the other two groups. Situational crises were considered more important motivators by the knowledgeable group than by the moderately knowledgeable group who ranked this item last. The knowledgeable group considered lack of ability or training less important as a factor causing poor work performance than did the other two groups. This may reflect a greater awareness of the significance of behavioral health problems. However, the knowledgeable supervisors did not differ from the other groups in their ranking of factors which contribute to effective treatment.

ROLE OF THE SUPERVISOR

Program knowledge was associated with differences in perception of program resources (Table 34). Knowledgeable supervisors ranked the medical department relatively highly and the employee assistance counsellor as low in importance. The least knowledgeable group saw the personnel officer as a more important resource than did the others.

Table 33

Program Philosophy

Comparison by Knowledge of Program
(Rank Order by Importance of Item)

Item	Know	Don't Know	Know to Some Extent
PURPOSE OF PROGRAM			
Program Purpose is to:			
Assist employees	1	1	1
Assist supervisors	2	2.5	2
Improve organization	3	2.5	3
Reduce illness	4	4	5
Save money	5	5	4
Program Benefits:			
Employee	1	1	1
Employer	2	2	2
Supervisor	3	3	3
Society	4	4	4
Union	5	5	5
PROGRAM CONCEPT			
Poor Work Performance is Due to:			
Other behavioral health problems	1	1	1
Work situation	2	3	3
Lack of ability/training	4	2	2★
Alcoholism	3	4	4
Inappropriate management	5	5	5
Source of Motivation:			
Personal responsibility	5	1	1★
Family & social pressure	3	2	2
Situational crises	2	3	5☆
Confrontation by supervisor	1	5	3.5★
Professional/medical information	4	4	3.5
Treatment Effectiveness Depends On:			
Attendance by employee	1	1	1
Appropriateness	2	2	2
Accessibility	3	3	3
Quality of service	4	4	4
Coordination with work place	5	5	5

Note: Order of items reflects rank order for total group (see Table 14).

☆ Rank order difference > 1.

★ Rank order difference > 1 and mean difference > .5.

Table 34

The Supervisor's Role in the Program

Comparison by Knowledge of Program (Rank Order by Importance of Item)

Item	Know	Don't Know	Know to Some Extent
Supervisor's responsibility is to:			
Face employee with his responsibility	1	1	1.5
Involve employee in treatment	2	2	3
Represent employer	3	3	1.5
Get the job done	4	4	4
Protect employee rights	5	5	5
Supervisor's prime resource is:			
His supervisor	1	1	1
Program counselor	4.5	2	3★
Personnel officer	4.5	3	4.5☆
Company policy	3	4	2☆
Medical department	2	5	4.5★
Supervisor helps employee most by:			
Showing personal concern	1	1	1
Good supervision	3	2	2
Offering professional referral	2	3	3
Firm discipline	4	4	4
Constructive coercion	5	5	5
Decision to refer should be made by:			
Immediate supervisor	1	1	1
Program counselor	2	2	2
Senior manager	3	3	3
Personnel officer	4	4	4
Union steward	5	5	5
Supervisor can refer most effectively:			
via Program counselor	3	1	1☆
via Manager or personnel	2	2	2
via Medical department	1	3	3★
Directly	4	4	4
via Union representative	5	5	5

Note: Order of items reflects rank order for total group (see Table 14).

☆Rank order difference > 1.

★Rank order difference > 1 and mean difference > .5.

Company policy was considered more important by the moderately knowledgeable group as compared to the least knowledgeable group. They also considered that representing the employer's interest was more important than did either the most knowledgeable or the least knowledgeable groups.

The most knowledgeable group considered the medical department a more important resource in making referrals than the employee assistance counsellor. This opinion was the reverse of that expressed by the other two groups.

The above findings appear to suggest that increased program knowledge is associated with increased reliance on the medical department as opposed to the program counsellor. However, a comparison of sub-groups by employer (see Table 15) suggests another interpretation. Here, the sub-groups which rely most heavily on the program counsellor as the supervisor's resource and referral facilitator are those which have a counsellor available within their employer's program. Consequently, it appears that increased program knowledge encourages supervisors to utilize the resource which is most readily available. Because this is the medical department in at least half of the employer groups, the results in the present section suggest that medical departments are not recognized as a resource by many supervisors unless this is brought to their attention through training in the program.

PROGRAM COMPONENTS

Knowledge about the program is primarily associated with differences in the supervisors' attitude toward constructive coercion and the role of the employer in Table 35. Knowledgeable supervisors endorsed the use of constructive coercion with alcoholic employees much more strongly than did the other groups. In addition, they were less opposed to the use of this technique with other problem employees. They disagreed more strongly, as well, with the concept that most problem employees are willing to accept treatment voluntarily.

The knowledgeable group also felt much more confident that senior management supports them in utilizing the program than did the uninformed group. The know-

Table 35

Program Components

Comparison by Knowledge of Program
(mean response to statements given)

Statements	Know	Don't Know	Know to Some Extent
RATIONALE			
Need for program			
Incidence of behavioral health problems is significant	2.4	2.7	2.8
Behavioral health problems are costly	1.6	1.8	1.6
Employer has the right to implement behavioral health program	1.5	1.7	1.5
Most behavioral health problems are alcohol related	3.1	3.2	3.3
Work environment causes behavioral health problems	2.3	2.2	2.2
Motivation to accept treatment			
Threat of dismissal effectively motivates alcoholics	2.5	3.2	3.2†
Threat of dismissal effectively motivates employees with other behavioral health problems	3.2	3.6	3.9†
Most problem employees accept treatment voluntarily	3.6	3.1	3.4†
Treatment effectiveness			
Treatment resolves behavioral health problems	2.1	2.2	2.3
Effective treatment restores work performance	1.9	2.2	2.1
Community treatment resources are readily available	2.2	2.5	2.4
COORDINATION OF PROGRAM ELEMENTS			
Union conflicts with program	3.4	3.2	3.5
Union/management cooperation is needed	1.6	1.7	1.8
Senior management supports supervisor	1.8	2.4	2.0†
Professional consultation is available	2.1	2.8	2.7†
Treatment agency and work place should cooperate	1.8	1.7	1.7
Treatment agencies work with supervisors	2.4	2.5	2.6
Diagnostic and referral service is needed	1.8	1.8	1.8
PROGRAM POLICY			
Key statements			
Behavioral health problems are illnesses	1.5	1.8	1.6
Adequate benefits are provided	1.8	2.0	1.8
Problem employees should accept referral	2.0	2.3	2.1
Continued poor performance should result in discipline	2.0	2.2	1.9
Additional statements			
Program participation does not affect job security	2.3	2.2	2.1
Supervisor should be concerned only with work performance	3.7	3.9	3.8
Confidentiality is protected	2.1	2.2	2.2
Program limits personnel policy enforcement	3.5	3.3	3.4
Employee should seek help early	2.4	2.8	3.0†
Supervisor's program training is adequate	3.2	3.9	3.7†

†Mean difference ⩾ .5.

ledgeable supervisors also agreed more strongly than did either of the other groups that adequate professional consultation was available to them.

With regard to policy statements, the well informed group agreed much more strongly than did the uninformed group that employees are responsible to seek help on their own when they first develop a behavioral health problem. It is also noted that they disagreed less strongly with the concept that adequate training is provided to supervisors about the program.

In spite of lower program utilization by knowledgeable supervisors, it appears that they had a more positive general attitude toward the program and a better understanding of constructive coercion as a means of appealing to the problem employee's sense of responsibility. However, most issues concerning program rationale, coordination of program elements and program policy were viewed similarly by all groups, regardless of their knowledge of the program.

PROGRAM PROCESS

Several differences of opinion on practical program matters are associated with the level of knowledge about the program in Table 36. Supervisors who did not know how to use the program were more inclined to handle performance problems without formal documentation. Of the three groups, the knowledgeable supervisors were most supportive of the statement that identification of problem employees is always in the employee's best interests. The least supportive group consisted of the moderately knowledgeable supervisors.

Motivational issues were again the major source of differences in opinion. The knowledgeable supervisors differed from the other two groups in that they were more inclined to believe that they have the necessary authority to motivate problem employees by using constructive coercion and they consider this as part of their job. They are also more confident of support from senior management.

Table 36

Program Process

Comparison by Knowledge of Program
(mean response to statements given)

Statements	Know	Don't Know	Know to Some Extent
Identification			
Poor performance indicates a behavioral health problem	2.4	2.4	2.6
Most poor performers have behavioral health problems	3.1	2.8	3.1
Performance standards are fair and clear	2.3	2.7	2.5
Poor performance often need not be documented	3.0	2.2	2.8†
Supervisor is best identifier of employees with behavioral health problems	2.0	1.9	1.9
Supervisor's failure to identify problem employee contributes to the problem	1.5	1.8	1.8
Supervisor usually knows *why* an employee performs poorly	3.0	3.3	3.4
Identification is in employee's best interests	1.8	2.0	2.3†
Identification should occur early	1.6	1.6	1.7
Program involvement is in employee's best interests	1.6	1.7	1.8
Motivation			
Supervisor has coercive authority	2.8	3.2	3.3†
Coercion is part of supervisor's job	2.3	3.1	3.1†
Coercion is in employee's best interests	2.5	2.8	2.8
Coercion may disrupt supervisor/employee relationship	3.0	3.2	2.8
Senior management supports the supervisor in a grievance	2.1	2.6	2.3†
Coercion may harm the employee	3.0	2.8	2.8
Referral			
Supervisor can select appropriate treatment agency	3.5	3.9	3.8
Coordination between treatment and work is important	2.1	1.8	1.9
Supervisor has adequate input to treatment agency	2.9	3.3	3.2
Supervisor receives adequate feedback from treatment agency	2.9	3.0	2.9
Many problems resolve themselves without treatment	3.5	3.3	3.4
Coercion reduces treatment effectiveness	3.2	2.9	2.9

† Mean difference ≥ .5.

COMPARISON BY UNION/MANAGEMENT AFFILIATION

Throughout the program literature, supervisors are referred to as the employer's representative. However, in many work settings (notably government employers in this study) union members are assigned supervisory duties. Consequently, a comparison has been made between those supervisors who identified themselves as managers with no union affiliation and those who identified themselves as union members with supervisory duties. Supervisors who did not identify themselves clearly as members of either group were excluded from this comparison.

DEMOGRAPHIC DATA (Table 37)

The two groups had virtually the same amount of experience as supervisors. However, the managers had somewhat more seniority with their present employer. Managers tended more often to be senior level supervisors but almost one-third of union members were at a senior level as well. As intimated earlier, a much higher percentage of managers had at least some knowledge of how to use the program. It is not clear, however, whether union members were less interested or had less access to program information.

PROGRAM UTILIZATION (Table 38)

The management group had supervised a much larger number of employees than had the union members. A higher percentage of management supervisors had also reported having problem employees. However, the union members had identified a higher percentage of their subordinates as problem employees.

In both groups, constructive coercion was utilized approximately twice as frequently as voluntary referral. However, management supervisors had utilized these strategies in a higher percentage of problem cases. A smaller percentage of union members had utilized these strategies in comparison to the managers. This discrepancy was greatest with regard to the offer of voluntary referral.

PROGRAM PHILOSOPHY (Table 39)

The two groups differed very little in their view of program philosophy.

Table 37

Demographic Data

Comparison by Managerial Affiliation

	Managers	Union Members
	N = 130	
	Mean	Mean
Average years in supervisory position	10.3	10.4
Average years with present employer	15.4	12.1
	Percent	Percent
Percent of total group identified according to union/management affiliation as exclusively managers	58.6	31.0
Percent in senior supervisory positions	62.4	35.6
Percent who are confident they know how to use the program	40.0	4.4
Percent with at least some knowledge of how to use the program	92.9	42.2

Table 38

Program Utilization

Comparison by Managerial Affiliation

	Managers	Union Members
	Mean	Mean
Average number of employees supervised in past year	50.2	13.6
Average number of problem employees recognized	6.1	2.2
	Percent	Percent
Percent of supervisors who reported having problem employees	64.7	46.7
Percent of employees considered to be "problems"	12.2	16.5
Percent of problem employees* who were:		
–offered voluntary referral	6.3	4.0
–"constructively coerced"	12.1	8.9
Percent of supervisors with problem employees		
–who offered voluntary referral	30.9	14.3
–who used constructive coercion	27.3	23.8
	N=85	N=45

*From Table 11.

Table 39

Program Philosophy

Comparison by Managerial Affiliation
(Rank Order by Importance of Item)

Item	Managers	Union Members
PURPOSE OF PROGRAM		
Program Purpose is to:		
Assist employees	1	1
Assist supervisors	2	2
Improve organization	3	3
Reduce illness	4	5
Save money	5	4
Program Benefits:		
Employee	1	1
Employer	2	2
Supervisor	3	3
Society	4	4
Union	5	5
PROGRAM CONCEPT		
Poor Work Performance is Due to:		
Other behavioral health problems	1	1
Work situation	2.5	3.5
Lack of ability/training	2.5	2
Alcoholism	4	3.5
Inappropriate management	5	5
Source of Motivation:		
Personal responsibility	1.5	1
Family & social pressure	1.5	2
Situational crises	3	5☆
Confrontation by supervisor	4	4
Professional/medical information	5	3☆
Treatment Effectiveness Depends On:		
Attendance by employee	1	1
Appropriateness	2.5	2
Accessibility	2.5	3
Quality of service	4	4
Coordination with work place	5	5

Note: Order of items reflects rank order for total group (see Table 14).
☆Rank order difference > 1.

The only notable difference in this section related to the relative importance of situational crises as compared to professional/medical information as a source of motivation. The managers considered situational crises more important whereas union members favored the importance of medical information.

ROLE OF THE SUPERVISOR

The two groups also expressed very similar opinions with regard to their role as a supervisor (Table 40). However, managers considered company policy as a more important resource whereas union members relied more on the personnel officer, perhaps reflecting their more limited authority to implement policy.

PROGRAM COMPONENTS

No major differences of opinion were found between the two groups on issues concerning the program rationale, coordination of program elements and program policy (Table 41). On items relating directly to union involvement, union members disagreed a little more strongly with the statement that the union's role tends to conflict with the assistance program. Managers were somewhat more convinced that union/management cooperation is needed for program success.

PROGRAM PROCESS

Table 42 reveals minimal differences between these two groups of supervisors with regard to the program process. Union members were, however, more in favor of handling poor work performance on an informal basis and indicated more strongly that they do not believe they have the necessary authority to utilize constructive coercion. However, they did not believe that constructive coercion would disrupt the working relationship between the supervisor and the employee. This contrasted with the managers who expressed mild agreement with this item.

It would appear that union members with supervisory duties do not differ appreciably in their view of the program from managers who have no union affiliation.

Table 40

The Supervisor's Role in the Program

Comparison by Management Affiliation
(Rank Order by Importance of Item)

Item	Managers	Union Members
Supervisor's responsibility is to:		
Face employee with his responsibility	1	1
Involve employee in treatment	2.5	3
Represent employer	2.5	2
Get the job done	4	4
Protect employee rights	5	5
Supervisor's prime resource is:		
His supervisor	1	1
Program counselor	3.5	2.5
Personnel officer	5	2.5☆
Company policy	2	4★
Medical department	3.5	5
Supervisor helps employee most by:		
Showing personal concern	1	1
Good supervision	2	2
Offering professional referral	3	3
Firm discipline	4	4
Constructive coercion	5	5
Decision to refer should be made by:		
Immediate supervisor	1	1
Program counselor	2	2
Senior manager	3	3
Personnel officer	4	4
Union steward	5	5
Supervisor can refer most effectively:		
via Program counselor	2	1
via Manager or personnel	1	2
via Medical department	3	3
Directly	4	4
via Union representative	5	5

Note: Order of items reflects rank order for total group (see Table 14).
☆Rank order difference > 1.
★Rank order difference > 1 and mean difference > .5.

Table 41

Program Components

Comparison by Management Affiliation
(mean response to statements given)

Statements	Managers	Union Members
RATIONALE		
Need for program		
Incidence of behavioral health problems is significant	2.7	2.8
Behavioral health problems are costly	1.6	1.8
Employer has the right to implement behavioral health program	1.6	1.5
Most behavioral health problems are alcohol related	3.3	3.0
Work environment causes behavioral health problems	2.2	2.2
Motivation to accept treatment		
Threat of dismissal effectively motivates alcoholics	2.9	3.2
Threat of dismissal effectively motivates employees with other behavioral health problems	3.5	3.7
Most problem employees accept treatment voluntarily	3.5	3.2
Treatment effectiveness		
Treatment resolves behavioral health problems	2.2	2.4
Effective treatment restores work performance	2.0	2.1
Community treatment resources are readily available	2.4	2.3
COORDINATION OF PROGRAM ELEMENTS		
Union conflicts with program	3.3	3.6
Union/management cooperation is needed	1.6	2.0
Senior management supports supervisor	1.9	2.2
Professional consultation is available	2.4	2.8
Treatment agency and work place should cooperate	1.8	1.7
Treatment agencies work with supervisors	2.5	2.4
Diagnostic and referral service is needed	1.8	1.8
PROGRAM POLICY		
Key statements		
Behavioral health problems are illnesses	1.5	1.7
Adequate benefits are provided	1.8	2.0
Problem employees should accept referral	2.0	2.4
Continued poor performance should result in discipline	1.9	2.2
Additional statements		
Program participation does not affect job security	2.1	2.0
Supervisor should be concerned only with work performance	3.8	3.8
Confidentiality is protected	2.2	2.1
Program limits personnel policy enforcement	3.3	3.5
Employee should seek help early	2.7	2.9
Supervisor's program training is adequate	3.5	3.8

Table 42

Program Process

Comparison by Management Affiliation (mean response to statements given)

Statements	Managers	Union Members
Identification		
Poor performance indicates a behavioral health problem	2.4	2.5
Most poor performers have behavioral health problems	3.1	2.9
Performance standards are fair and clear	2.4	2.6
Poor performance often need not be documented	2.9	2.3†
Supervisor is best identifier of employees with behavioral health problems	1.9	1.9
Supervisor's failure to identify problem employee contributes to the problem	1.7	1.8
Supervisor usually knows *why* an employee performs poorly	3.2	3.2
Identification is in employee's best interests	2.1	2.0
Identification should occur early	1.6	1.7
Program involvement is in employee's best interests	1.7	1.8
Motivation		
Supervisor has coercive authority	3.0	3.5†
Coercion is part of supervisor's job	2.8	3.2
Coercion is in employee's best interests	2.8	2.7
Coercion may disrupt supervisor/employee relationship	2.8	3.3†
Senior management supports the supervisor in a grievance	2.3	2.4
Coercion may harm the employee	2.8	3.0
Referral		
Supervisor can select appropriate treatment agency	3.8	3.7
Coordination between treatment and work is important	1.9	1.8
Supervisor has adequate input to treatment agency	3.1	3.3
Supervisor receives adequate feedback from treatment agency	2.9	2.9
Many problems resolve themselves without treatment	3.4	3.4
Coercion reduces treatment effectiveness	2.9	3.2

† Mean difference ≥ .5.

They do, however, make less use of the program in spite of a higher awareness of the existence of problem employees.

COMPARISON BY LEVEL OF POSITION

A number of writers have suggested that the assistance program is utilized primarily by front line supervisors. It is assumed that the difference in utilization reflects differences in the supervisor's roles as well as differences in their perception of the program. Therefore, a comparison was made between senior and junior supervisors.

Junior supervisors are defined as front line supervisors who are responsible only for non-supervisory employees. Senior supervisors have subordinates who are, themselves, supervisors (ranging from junior foremen to senior managers) although they may also have some responsibility for front line supervision.

DEMOGRAPHIC DATA

Senior supervisors had somewhat more supervisory experience and considerably more seniority with their present employer than did junior supervisors (Table 43). Each group comprised approximately half of the total sample.

More than twice as many seniors as juniors identified themselves as managers with no union affiliation. A greater proportion were also knowledgeable about the program.

PROGRAM UTILIZATION

Senior supervisors had been responsible for a larger number of employees than had juniors and had recognized more problem employees on average. In addition, they had identified a slightly larger percentage of their subordinates as problem employees. However, junior supervisors utilized the program more actively as shown in the higher rate of use of voluntary referrals and constructive coercion (Table 44). These differences are not as striking as the literature would suggest. It is noted, however, that a larger percentage of junior supervisors reported having problem employees and utilizing program action. This was particularly evident with regard to the use of constructive coercion.

Table 43

Demographic Data

Comparison by Level of Position

	Senior Supervisors	Junior Supervisors
	N = 145	
	Mean	Mean
Average years in supervisory position	11.6	9.2
Average years with present employer	17.1	11.5
	Percent	Percent
Percent of total group identified by level of position	51.8	48.3
Percent with exclusively management affiliation	69.3	32.9
Percent who know definitely how to use the program	36.8	15.7
Percent with at least some knowledge of how to use the program	81.6	65.7

Table 44

Program Utilization

Comparison by Level of Position

	Senior Supervisors	Junior Supervisors
	Mean	Mean
Average number of employees supervised in past year	40.9	29.3
Average number of problem employees recognized	5.3	3.5
	Percent	Percent
Percent of supervisors who reported having problem employees	52.0	61.4
Percent of employees considered to be "problems"	13.1	11.9
Percent of problem employees* who were:		
–offered voluntary referral	5.7	7.4
–"constructively coerced"	10.5	12.3
Percent of supervisors with problem employees		
–who offered voluntary referral	17.3	23.3
–who used constructive coercion	10.7	27.9
	N=75	N=70

*From Table 11.

PROGRAM PHILOSOPHY

Junior and senior supervisors were very similar in their view of the program's purpose and concept. The only notable differences occurred in their ranking of various sources of motivation (Table 45). Junior supervisors favored confrontation and threat of dismissal more highly whereas senior supervisors relied more heavily on the use of situational crises.

ROLE OF THE SUPERVISOR

In Table 46 the major differences between the two groups relate to their view of the supervisors' program resources. Senior supervisors considered the medical department and the employee assistance counsellor as more important resources than did junior supervisors who relied more heavily on company policy. In all other respects, both groups had very similar views.

PROGRAM COMPONENTS

No major differences were noted between the two groups in their view of the program rationale, coordination of elements and policy (Table 47).

PROGRAM PROCESS

Only one notable difference was found between senior and junior supervisors in this section (Table 48). Senior supervisors responded somewhat more favorably to the suggestion that the supervisor has the necessary authority to motivate problem employees through the use of constructive coercion. It is interesting to note that, in spite of this, they had reported much less use of constructive coercion (see Table 44).

In summary, very few differences were noted between senior and junior supervisors in their view of the program. However, junior supervisors utilized the program somewhat more actively although senior supervisors were slightly more aware of the existence of problem employees.

Table 45

Program Philosophy

Comparison by Level of Position
(Rank Order by Importance of Item)

Item	Senior Supervisors	Junior Supervisors
PURPOSE OF PROGRAM		
Program Purpose is to:		
Assist employees	1	1
Assist supervisors	2.5	2
Improve organization	2.5	3
Reduce illness	5	4
Save money	4	5
Program Benefits:		
Employee	1	1
Employer	2	2
Supervisor	3	3
Society	4	4
Union	5	5
PROGRAM CONCEPT		
Poor Work Performance is Due to:		
Other behavioral health problems	1	1
Work situation	2	2.5
Lack of ability/training	3	2.5
Alcoholism	4	4
Inappropriate management	5	5
Source of Motivation:		
Personal responsibility	1	1
Family & social pressure	2.5	2.5
Situational crises	2.5	4.5☆
Confrontation by supervisor	5	2.5★
Professional/medical information	4	4.5
Treatment Effectiveness Depends On:		
Attendance by employee	1	1
Appropriateness	2	2
Accessibility	3	3
Quality of service	4	4
Coordination with work place	5	5

Note: Order of items reflects rank order for total group (see Table 14).
☆Rank order difference > 1.
★Rank order difference > 1 and mean difference > .5.

Table 46

The Supervisor's Role in the Program

Comparison by Level of Position
(Rank Order by Importance of Item)

Item	Senior Supervisors	Junior Supervisors
Supervisor's responsibility is to:		
Face employee with his responsibility	1	1
Involve employee in treatment	3	2
Represent employer	2	3
Get the job done	4	4
Protect employee rights	5	5
Supervisor's prime resource is:		
His supervisor	1	1
Program counselor	2	4☆
Personnel officer	4	3
Company policy	5	2★
Medical department	3	5☆
Supervisor helps employee most by:		
Showing personal concern	1	1
Good supervision	2	2
Offering professional referral	3	3
Firm discipline	4	4
Constructive coercion	5	5
Decision to refer should be made by:		
Immediate supervisor	1	1
Program counselor	2	2
Senior manager	3	3
Personnel officer	4	4
Union steward	5	5
Supervisor can refer most effectively:		
via Program counselor	1	2
via Manager or personnel	2	1
via Medical department	3	3
Directly	4	4
via Union representative	5	5

Note: Order of items reflects rank order for total group (see Table 14).
☆Rank order difference > 1.
★Rank order difference > 1 and mean difference > .5.

Table 47

Program Components

Comparison by Level of Position
(mean response to statements given)

Statements	Senior Supervisors	Junior Supervisors
RATIONALE		
Need for program		
Incidence of behavioral health problems is significant	2.8	2.6
Behavioral health problems are costly	1.6	1.7
Employer has the right to implement behavioral health program	1.6	1.5
Most behavioral health problems are alcohol related	3.3	3.1
Work environment causes behavioral health problems	2.2	2.3
Motivation to accept treatment		
Threat of dismissal effectively motivates alcoholics	3.1	3.0
Threat of dismissal effectively motivates employees with other behavioral health problems	3.6	3.6
Most problem employees accept treatment voluntarily	3.4	3.4
Treatment effectiveness		
Treatment resolves behavioral health problems	2.2	2.3
Effective treatment restores work performance	2.0	2.2
Community treatment resources are readily available	2.4	2.3
COORDINATION OF PROGRAM ELEMENTS		
Union conflicts with program	3.5	3.2
Union/management cooperation is needed	1.7	1.8
Senior management supports supervisor	2.0	2.1
Professional consultation is available	2.6	2.5
Treatment agency and work place should cooperate	1.7	1.8
Treatment agencies work with supervisors	2.4	2.6
Diagnostic and referral service is needed	1.8	1.8
PROGRAM POLICY		
Key statements		
Behavioral health problems are illnesses	1.6	1.6
Adequate benefits are provided	1.9	1.9
Problem employees should accept referral	2.1	2.2
Continued poor performance should result in discipline	2.0	2.1
Additional statements		
Program participation does not affect job security	2.0	2.3
Supervisor should be concerned only with work performance	3.8	3.8
Confidentiality is protected	2.1	2.2
Program limits personnel policy enforcement	3.5	3.3
Employee should seek help early	2.9	2.7
Supervisor's program training is adequate	3.7	3.6

Table 48

Program Process

Comparison by Level of Position
(mean response to statements given)

Statements	Senior Supervisors	Junior Supervisors
Identification		
Poor performance indicates a behavioral health problem	2.4	2.5
Most poor performers have behavioral health problems	3.2	2.9
Performance standards are fair and clear	2.4	2.6
Poor performance often need not be documented	2.8	2.6
Supervisor is best identifier of employees with behavioral health problems	2.1	1.8
Supervisor's failure to identify problem employee contributes to the problem	1.7	1.7
Supervisor usually knows *why* an employee performs poorly	3.3	3.2
Identification is in employee's best interests	2.0	2.2
Identification should occur early	1.7	1.6
Program involvement is in employee's best interests	1.9	1.6
Motivation		
Supervisor has coercive authority	2.9	3.4†
Coercion is part of supervisor's job	2.8	3.0
Coercion is in employee's best interests	2.9	2.6
Coercion may disrupt supervisor/employee relationship	2.9	3.0
Senior management supports the supervisor in a grievance	2.2	2.4
Coercion may harm the employee	2.7	3.1
Referral		
Supervisor can select appropriate treatment agency	3.6	3.9
Coordination between treatment and work is important	1.9	1.9
Supervisor has adequate input to treatment agency	3.1	3.2
Supervisor receives adequate feedback from treatment agency	2.9	2.9
Many problems resolve themselves without treatment	3.2	3.6
Coercion reduces treatment effectiveness	3.0	3.0

†Mean difference ≥ .5.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

A critical review of existing literature led to a definition of the employee assistance program concept on which this study was based. It was proposed that employee assistance programs should be directed toward enhancing behavioral health in the work place. Several basic implications were noted.

The focus on improved behavioral health requires that a comprehensive range of behavioral health problems be included as the area of concern, rather than restricting the program to alcoholism. The emphasis on health also serves to place secondary goals such as cost savings, case finding, productivity, extension of benefits, etc. into their proper perspective. Additionally, the concern with behavioral health implies the need for a broad, psycho-social approach to health problems as opposed to the traditional medical model. Health is defined in terms of effective functioning. However, it was noted that professional involvement, which had been de-emphasized in alcoholism programs, is recognized as a vital component of the comprehensive program concept. The concern with health issues also requires that the program be defined as a means of providing help to employees with problems rather than as a means of forcing them to cooperate with treatment.

The second major implication of the comprehensive behavioral health approach is that the work place be recognized as a legitimate and equal partner in the program with the treatment community. This partnership is based on the assumption that improved health of the employee results in improved health of the employing organization and is associated with the healthfulness of the organizational, social and physical environment of the work place.

If the work place is accepted as a viable program component, it follows that the program should be designed to be relevant to the work place and should not require the work place to be restructured in order to fit the needs of the program. It was noted that traditional programs have significantly altered the definition of roles and responsibilities of supervisors, union stewards, senior managers, personnel officers and resource personnel. However, it was proposed that existing roles and responsibilities be utilized more effectively without being altered as the program's success must ultimately depend on its ability to adapt to the existing realities of the work place. Finally, it was noted that the cooperative nature of the program requires the implementation of an effective coordinating mechanism. The need for a diagnostic and referral service has been recognized by most program designs but has not been extensively implemented.

The above perspective on the employee assistance program concept was developed on the basis of existing literature and was utilized as a framework within which various aspects of the program were examined in this study. In the following sections a number of conclusions are drawn from the findings about the supervisor's view of the program and recommendations are made for the development of a program which will hopefully be more compatible with the work place and, as a result, be utilized more extensively and more effectively by the supervisors.

PROGRAM UTILIZATION BY SUPERVISORS

INCIDENCE OF PROBLEM EMPLOYEES

The supervisors in this study identified 12.6% of the work force as problem employees. Of these, only 2.5% improved their work performance with no corrective action on the part of the supervisor. Therefore, the problems identified were real and ongoing. Thus, this may well be an under-estimate rather than over-estimate, of the actual incidence of problem employees. It must be concluded that the proportion of problem employees in the work place is much higher than has been estimated by most programs.

A second conclusion is that supervisors are much more aware of the existence of problem employees than most program penetration rates would indicate. It follows that failure to recognize problem employees is not the major obstacle to program utilization.

The concern also appears unfounded that supervisors may lose their "readiness to act" because of relatively infrequent encounters with problem employees. It is noted that during the previous year the average supervisor recognized 4.5 problem employees under his immediate supervision. If the "turnover rate" is taken into account, these figures may be interpreted to mean that approximately 22% of the employee positions under a supervisor during the course of a year would be filled by employees who are evidencing work performance problems.

PENETRATION RATE

In spite of the high rate of recognition of problem employees by supervisors, only a small minority (10.8%) of problem employees were involved in the assistance program in some way. It must be concluded that lack of utilization represents a major shortcoming of the program.

It would appear that the quality, as well as the quantity, of program utilization is somewhat deficient. It is noted that in most cases where an employee was offered referral for treatment (including voluntary as well as coercive offers) the supervisor was unable to indicate whether the offer had been accepted or refused. At Canadian National Railways, where 35 employees had been placed under constructive coercion, only two were listed as having accepted the offer of treatment. Although the intent of this study was not to evaluate the effectiveness of individual programs, the findings do indicate a deplorable lack of follow-through on program actions and a lack of evidence that the program was successful. For example, of the 42% of constructively coerced employees who were accounted for, only 53% remained on the job and improved in their work performance. It is also noted that 74 employees had been placed under constructive coercion (see Table 11) but in only

45 cases (60.0%) was constructive coercion considered the most intensive action taken. It must be concluded, therefore, that in almost 40% of cases where constructive coercion was used the employee was promptly dismissed (in addition to 11% later on), or that constructive coercion was defined by supervisors as a somewhat tentative action which was followed by more intensive measures. This latter explanation strongly negates the accepted definition of constructive coercion as a powerful strategy for bringing employee problems to a definite conclusion.

The findings revealed that most corrective actions directed at problem employees were initiated by their immediate supervisor who favored informal problem solving as a means of correcting the problem. Senior managers and personnel officers initiated a significant percentage of dismissals, transfers and program actions. Senior managers also had an indirect supervisory role in relation to a relatively large number of employees. It must be concluded, therefore, that senior managers should be recognized as important participants in the program and that front line supervisors should not be defined as having sole responsibility for program utilization. This conclusion is confirmed by the high ranking of senior supervisors by the sample group as their primary resource within the program.

The overall conclusion with regard to program utilization is that programs are currently not successful in penetrating the population of problem employees. The central problem appears to be lack of program utilization by supervisors. This, in turn, suggests that deficiencies in the design of the program need to be corrected in order to gain supervisory acceptance before intensive efforts are directed at marketing these programs.

THE SUPERVISOR'S VIEW OF THE PROGRAM RATIONALE

PURPOSE OF THE PROGRAM

Supervisors differed markedly from most writers in the area in their view of the need for programs and their definition of program goals. Thus, the very reason for the existence of programs is brought into question.

Need for Program

The need for assistance programs is typically presented to employing organizations on the basis of the significant incidence of alcoholism and other behavioral health problems and a documentation of the costs associated with such problems. Supervisors endorsed the argument that employee problems are prevalent and costly. However, they rejected the assumption that alcohol-related problems are the primary issue of concern. Instead, they indicated a wider range of concerns which emphasized a variety of behavioral health problems and social/environmental difficulties as well as practical, situational misfortunes and problems arising out of the relationship between the employee and the work situation.

Supervisors also rejected the contention that their primary function is to represent the employer's interests. This was associated with a de-emphasis on concern with saving money or ensuring that the requirements of the job were met. Supervisors were also notably disinterested in the broader sociological significance of utilizing the work place as a means of reducing the incidence of untreated alcoholism in society.

A major concern expressed by supervisors related to the problem of determining when program involvement was needed for a specific employee. Many supervisors believe that they must diagnose the existence of a behavioral health problem before they can appropriately use the program. Thus, reliance on performance-based identification has not resolved the issue of the supervisor's involvement in diagnosing the employee's underlying health problem. Meanwhile, they are concerned with the employee's failure to function adequately and fear that their own intervention may be unfair and harmful to the employee. A major reason for needing a program, therefore, is to assist the supervisor in determining when a special approach should be taken and to assist him in resolving the majority of problems which he does not perceive as specifically health related.

Program Goals

Contrary to typical program directives that they should concern themselves exclusively with job performance, supervisors expressed a strong personal concern for the wellbeing of their employees and a need for constructive problem-solving techniques in dealing with difficulties which are not necessarily health related. This attitude may, in part, reflect the supervisors' confessed difficulty in understanding the concept of behavioral health problems. An initial step in resolving this difficulty would appear to be the adoption of a definition of behavioral health which is based on the criterion of the individual's ability to function effectively. In addition, the program needs to establish its relevance to the supervisors' typical perception of employee problems as resulting from situational hardships. For example, in a number of cases supervisors expressed reluctance to confront a problem drinking employee because they considered his drinking to result from marital conflict. They considered confrontation to constitute an unfair additional burden on the employee. Additionally, the supervisors tended to consider treatment as inappropriate in such situations because the wife was perceived as the "real" problem. Thus, the supervisor's immediate concern was not to get the problem employee into treatment, which they equated with upgrading his performance, but rather to offer support and lenience in view of the employee's unfortunate circumstances which were considered to be beyond the supervisor's, or the employee's, control.

The supervisors' concept of employee problems requires that the purpose of the program be re-formulated. The reason for implementing a program should be based on the need to resolve the dilemma that behavioral health problems pose to management rather than on management's obligation to provide help to the employee. From the manager's perspective, such problems need to be resolved because they have a serious adverse effect on the total organization. However, because they involve complex clinical and ethical issues, these problems are not amenable to management's usual problem-solving procedures. Consequently, professional input is needed and must be coordinated with the work situation in order to provide a problem-solving strategy to management. If such assistance is made available, the effectiveness and wellbeing of the organization will be enhanced and a variety of additional benefits will be realized, i.e., employees with health problems will receive treatment, the employer will save money and society will experience less disruption from untreated disorders. However, the fair and effective resolution of organizational problems must receive priority if the program is to be widely implemented and utilized.

It should be noted that supervisors strongly agreed that the problem employee should be the prime beneficiary of the program. However, supervisors consider the employer as the secondary beneficiary. This implies that the supervisor does not presently benefit a great deal from the program and is, instead, simply placed under additional obligation by the presence of an assistance program. In most cases, the supervisor defined his own benefit from the program in terms of the advantage of having a problem employee rehabilitated. This points out the lack of the program's relevance to the supervisor as a strategy for resolving his own managerial dilemma.

ROLE OF THE WORK PLACE

Most current programs are based on the assumption that the work place can be effectively utilized as a case finding and motivating mechanism within the context of the comprehensive health services delivery system. However, a reversal of this approach is clearly needed in order to ensure the program's relevance to the supervisor, i.e., it is the work place that should be utilizing the program as a means of meeting its legitimate objectives. If it is true that poor work performance is associated with the existence of underlying behavioral health problems and if the work place, in fact, has characteristics which make the program concept viable, it follows that the integrity of the work place should be respected in the design and implementation of the program. It also follows that if the program is directed toward the resolution of work performance problems, the desired health benefits will be obtained. Thus, it is recommended that the program's emphasis on treatment should be concentrated in the description of the treatment agency's role rather than being emphasized as a supervisory responsibility. This would free the supervisor to relate to the program within the familiar context of work-related issues rather than impose a quasi-clinical role on him.

A second issue concerning the role of the work place relates to the assumptions made about the work place by the writers who define the program. It is assumed that the work place has clearly defined standards which make identification of work performance problems, and the underlying behavioral health problems, possible. Motivation of problem employees is assumed to depend on the supervisor's authority to employ sanctions against employees who persistently fail to perform their job functions. However, the findings in this study suggest that performance standards are a matter of subjective interpretation and enforcement. Although standards do exist, they are often too low to detect any but the most severely impaired employees. Unions tend to encourage maximum use of benefits such as sick leave, and established practice often includes tolerance of a wide range of performance levels. Therefore, it is often inappropriate to interpret low performance as indicative of personal dysfunction on the part of the employee rather than simply conformity to group norms. Consequently, supervisors often find that they can best obtain the employee's cooperation by avoiding strict adherence to formal performance standards. In addition, supervisors perceive themselves as having limited authority to apply sanctions against unproductive employees. Thus, it is somewhat ironic that the program appears to require a level of disciplinary action by supervisors which goes well beyond their normal practice.

The potential role of the work place as a key component in the program is further restricted by its isolation from the treatment component. Supervisors expressed a strong need for coordination between these two components. It is noted, however, that supervisors were much more aware of their need for liaison with the treatment agency at a practical rather than a conceptual level. They had little awareness of the potential benefits for the treatment resource in receiving support from the work place in providing ongoing coordination and motivating pressures during the treatment process. This finding serves to emphasize that coordination should be the responsibility of the program rather than of the supervisor.

Supervisors were also unfamiliar with the complexity of the delivery systems which provide various forms of treatment in the community. Consequently, they expressed a somewhat naive faith in the efficacy of treatment in the cases where they perceived this to be appropriate but failed to see treatment as directly applicable to performance problems. They did not share the concern expressed by several writers that the employing organization take some initiative in developing an increased responsiveness on the part of treatment resources to the particular needs of clients referred through occupational programs.

It should be noted that the conclusions in this section are based in large part on interview data and on inferences from the questionnaire. However, the supervisors' difficulty in relating to these concerns supports the concerns expressed in the literature that the supervisors need support from the program in coordinating their efforts with the treatment resource. A central recommendation, therefore, is that the program be defined in terms of the interaction between the work place and the treatment agency rather than as an occupationally based means of resolving behavioral health problems which interfere with work performance.

TREATMENT EFFECTIVENESS

The quality and nature of treatment has been seriously neglected in the program literature. Consequently, it is not surprising to note that supervisors view treatment as something that is done *to* the individual rather than actively utilized *by* him. This view implies that a condition requiring treatment is, by definition, a condition which absolves the employee of responsibility for his behavior. Thus, the treatment component is viewed as the antithesis of the basic program rationale which emphasizes the responsibility of the employee to take constructive action in resolving problems which contribute to poor performance. This attitude to treatment was reflected in the dichotomy defined by supervisors between health problems and performance problems.

Although supervisors were not very articulate on this topic, strong ambivalence was detected in their attitudes toward treatment. Not only did they define the majority of employee problems as outside the province of the treatment agency, but they also expressed grave concern that involvement in the program could be harmful to the employee. In many cases, they expressed the opinion that specific employee problems which they had encountered were not amenable to treatment. A large majority of supervisors indicated that they were not qualified to select a treatment agency.

The rationale for employee assistance programs depends heavily on the assumption that treatment is effective in resolving behavioral health problems and that this results in restored adequacy of work performance. However, the findings of this study show that supervisors do not perceive most performance problems as being the result of underlying behavioral health problems. Where such a relationship is perceived to exist, supervisors often manifest a naive faith in treatment as a somewhat magical solution. However, in most cases of poor work performance, considered to be caused by situational crises or factors other than behavioral health problems, supervisors do not perceive treatment as a relevant solution. In order to bridge this gap it is recommended that the traditional medical model be replaced with a psycho-social approach to treatment which takes into account the situational or environmental factors which concern the supervisor.

It would appear that traditional programs have responded to the supervisors' ambivalence about treatment by attempting to circumvent the need for treatment services in the work place. However, it would seem more constructive to ensure that adequate and appropriate treatment resources are incorporated as a central element of the program in the work setting. In this way the professional treatment resources would be in a position to provide practical consultation to supervisors who are dealing with situational work performance problems. Consequently, the onus of determining whether treatment is appropriate and the burden of faith in the treatment process is placed on the treatment professional rather than on the supervisor. This also implies that the problem situation and the employing organization itself are suitable recipients of treatment services, not just the employee who has been designated as a poor performer.

It is recommended that effective treatment must not only be provided but must be seen to be provided in the work place if supervisors are to risk becoming involved in an issue about which they have little knowledge and many subjective concerns.

The major recommendations with regard to provision of effective treatment are as follows. Because constructive coercion is defined as the precipitation of a crisis in the employee's life, it is essential that a crisis treatment resource be provided to ensure prompt and coordinated assistance to employees who have been persuaded to seek treatment. In addition, treatment resources in the community are often inaccessible because they are overloaded and because increasing specialization makes selection of an appropriate agency a difficult task. The existence of multiple problems underlying poor work performance has not been adequately explored. However, it is reasonable to assume that more than one treatment resource is frequently required. Thus, the limitations inherent in the treatment community strongly suggest the need for a "consumer advocate" to assist the employee in obtaining adequate and appropriate treatment when he is willing to accept this. The need for this type of behavioral health "case work" is reflected in the supervisors' low rating of the medical department as a source of motivation, as a resource to the supervisor and as the entity responsible for deciding if referral is appropriate.

It is noted that very little evidence has been presented in the literature demonstrating that treatment, obtained through occupational programs, is effective in resolving the employee's personal problems. Most of the success rates quoted are based largely on the employee's retention of his job. However, this may reflect a negative outcome from the supervisor's perspective if the employee is simply being motivated to do better out of fear or if his performance remains inadequate but the supervisor does not have the authority or the willingness to dismiss the employee. Consequently, there is little assurance available to the supervisor that treatment will actually prove to be helpful to the employee.

In summary, it is concluded from this study that supervisors consider the employee assistance program as irrelevant to their major concerns. Supervisors perceive most work performance problems as resulting from social/situational pressures rather than from specific health problems. Their primary concern is to provide help to unfortunate employees and they need help in differentiating between those who deserve help and those who should be held accountable for their unacceptable performance. It is recommended that the program be adapted to the supervisors' perception of the situation instead of depending on training to change his perceptions. This approach assumes that professional consultation and effective delivery of treatment services are not dependent on the supervisor's clinical skill but will prove to be viable and appropriate means of resolving the problems which are clearly recognized, if not well defined, by the supervisor.

THE SUPERVISOR'S VIEW OF THE PROGRAM PROCESS

IDENTIFICATION OF PROBLEM EMPLOYEES

As noted above, the program has not been adequately communicated to supervisors because it has been designed and enunciated from the perspective of the treatment delivery system rather than from the practical viewpoint of the work place. As a result, the administrators in the work place are required to carry out their program responsibilities within a context which is foreign to them. Consequently, the needs of the work place are not being adequately met and the program's potential for resolution of problems which impair the functioning of individuals and organizations has not been realized.

This study has demonstrated that supervisors recognize a significant number of problem employees. However, it is equally clear that in the great majority of cases they choose not to utilize the program and, therefore, do not formally identify them for purposes of the program. It must be concluded that the program's rationale, resources and its relevance to the work place must be re-examined if it is to be utilized to a significant extent. Account must be taken of the supervisors' preference for informal corrective action and the program's strong requirement for formal action.

Although supervisors recognize a large number of problem employees, it is also apparent that they fail to utilize the program in many cases where this would be appropriate. It has been recommended that a substantial increase in program utilization can best be accomplished by improving the quality of the program. However, it is also concluded that the supervisor should not be held solely responsible for the identification of problem employees and the decision to utilize the program. It is recommended that major emphasis be directed toward the involvement of senior managers, particularly with regard to the decision to utilize the program. In addition, provision needs to be made for problem employees to identify themselves through voluntary self referral. Programs which are perceived as offering practical assistance to employees have reported a high percentage of self referrals including a wide range of problems. A third recommendation with regard to identification of problem employees is that professional consultation be made available to managers at all levels in order to assist them in interpreting the significance of performance problems of which they are already aware.

MOTIVATION TO RESOLVE PROBLEMS

Constructive coercion, which is the primary technique of existing programs, is viewed with strong ambivalence by supervisors. The findings of this study suggest that supervisors experience a paralyzing dilemma between their formal obligations and their personal concerns. On the one hand, they accept their own obligation to confront employees with their responsibility to overcome ongoing problems. However, coercion is considered as a viable technique only when it is successful in obtaining the employee's co-operation. Thus, supervisors feel responsible if the employee refuses treatment or fails to benefit from it. This attitude reflects an important controversy in society at large concerning the individual's responsibility for his own choices and behavior when he is experiencing a mental, emotional or addictive illness. Not surprisingly, supervisors often conclude that constructive coercion is a potentially harmful, ineffective and risky strategy.

Two reasons have been identified for the unpopularity of constructive coercion. Firstly, supervisors believe strongly that motivation must come from within the employee and cannot be effectively imposed through external sanctions even when these can be successfully applied. The relationship between threat of job loss and the development of insight and acceptance of personal responsibility is a complex matter which requires an understanding of crisis theory. Therefore, it is not reasonable to expect supervisors to carry out this function without strong professional and administrative support. Secondly, the application of coercive techniques is constructive only in the presence of an active and viable offer of assistance. This implies that the program must provide to the supervisor a treatment resource which he can offer to the employee. Unless this is available, the coercive strategy becomes simply an obligation placed on an already troubled employee as the supervisors have suggested. This has serious ethical as well as practical implications for the supervisor. As noted above, constructive coercion has traditionally been defined as a central program technique. This has led to the emphasis, in this "helping" program, on increased disciplinary action by management. In reality, however, the coercive function is a normal part of the employment situation. Therefore, it is recommended that coercion not be defined as a program component but that the program be properly defined as a helping strategy utilized by the employer in an effort to resolve problems which would, otherwise, subject the employee to repeated and non-productive disciplinary measures which are provided for in the employment contract. This recommendation is based on the premise that managers currently avoid the use of legitimate discipline because they have no positive alternatives to suggest to employees who are unable to function effectively. However, if effective treatment is made available the normal disciplinary function of the work place will be re-established. As a result, the motivating power of the work place would be enhanced and program utilization would increase as a result of a more positive definition of the program's role.

Supervisors also made it clear that a wider range of motivational strategies is needed. The threat of job loss is considered inappropriate and unpractical in most cases of poor performance, especially when problem employees are identified early. It should be noted that the results of this study indicate that supervisors recognize problem employees much earlier than their rate of referral to the program would indicate. Therefore, a continuum of motivating techniques is required beginning with the provision of information to all employees that professional help is available to them and focusing, in the late stages of problem development, on confrontation with the reality of the employer's expectations and the inadequacy of the employee's performance. Threat of dismissal should be reserved for a "last-ditch effort" at salvaging severely dysfunctional employees. (Several supervisors noted in the interviews that their employers' primary form of motivation consisted of a post-discharge offer of re-employment if the employee was able to overcome his alcohol problem and maintain a reasonable period of sobriety.)

REFERRAL TO TREATMENT

The primary conclusion concerning this issue was that supervisors are not equipped to make effective referrals to community treatment agencies. It is reasonable to assume that senior managers, personnel officers, union stewards and other lay persons are similarly ill equipped to carry out the referral and coordinating function which requires considerable diagnostic skill and knowledge of treatment resources. The neglect of the referral function and its implications for coordination between the work place and the treatment agency represents a major shortcoming of existing programs. As a consequence, motivation has been considered only as a "one shot" responsibility of the work place; the potential involvement of the work place as a treatment resource has been overlooked; the potential for development of more adequate treatment resources through the input of occupational programs has been lost and the possibility of a synergistic relationship between occupational and treatment resources has remained unexplored.

PROGRAM RESPONSIBILITIES

NEED FOR DIAGNOSTIC AND REFERRAL SERVICE

Lack of coordination among the work place, the treatment agency and the ineffective employee is a reflection of the failure of assistance programs to provide a mechanism through which such coordination could be achieved. The concept of a diagnostic and referral service which would fulfill this role has been advocated in a majority of model program descriptions. However, implementation of a professionally staffed unit able to fulfill this function, as described in Chapter III, has been grossly neglected by traditional programs. It is concluded, however, that this type of service is of central importance in the establishment of an effective program. The role of such a unit would include a number of critical elements in the program. Consultation would be provided to supervisors, crisis services would be made available to referred employees, treatment services would be utilized more effectively by ensuring appropriate selection and providing adequate referral information, treatment effectiveness would be enhanced through coordination of motivational strategies and rehabilitative resources between the treatment agency and the work place, and the development of specialized services to meet the needs of occupational programs would be made possible. In addition, the existence of such a service makes it possible for the supervisor to *offer* help rather than obligate the employee to *seek* help. The service also ensures a higher degree of confidentiality and makes possible utilization of the work place as a resource to the treatment program. Problems which arise from conditions in the work place can be resolved more effectively because the work place, as well as the individual employee, becomes the subject of corrective action.

COORDINATION OF PROGRAM ELEMENTS IN THE WORK PLACE

A major source of ambivalence and confusion with regard to the program has resulted from the redefinition of roles within the work place to meet the requirements of the program. Supervisors are required to make clinical decisions under the guise of work performance issues; personnel officers are required to act as social case workers in liaison with treatment agencies; unions adopt a management role in joint administration of assistance programs and union stewards are asked to carry out a supervisory function in monitoring work performance and initiating corrective action. The supervisors in this study indicated clearly that they find this modification of traditional roles confusing and unsatisfactory. A strong recommendation is made, therefore, that the program be designed to utilize each of these elements in the work place within the context of their normal roles. It would seem that the confusion of roles has arisen from an ill-founded attempt to cope with complex behavioral health problems on a non-professional basis. This appears to be a legacy of the early alcoholism programs which relied almost exclusively on the corrective power of coercion itself, and on the novel concept of self-help through Alcoholics Anonymous. Numerous writers have discussed the limitations of the medical model in dealing with a wide range of behavioral health problems in a practical work setting. However, the conclusion should be drawn that a more adequate treatment model must be adopted and made more, rather than less, available to the work place. The present data suggest that effective professional involvement in the program and coordination of program elements can best be achieved through implementation of a confidential, objective and professional diagnostic, counselling and referral service. The lack of such a key program component must, necessarily, severely limit the scope and effectiveness of the program.

THE SUPERVISOR'S ROLE

The supervisors in this study have strongly indicated that the traditional assistance program placed them in the role of David wearing Saul's armor. There is no question that they play a key role in identifying and motivating problem employees to accept treatment. However, they should not be burdened with program responsibilities which go beyond their normal supervisory function. Supervisors can fulfill their role effectively only if they are allowed to function in partnership with a professional treatment resource and if the program is defined in such a way that the supervisor's normal managerial role is accepted as being compatible with the program's treatment goals. This includes provision of a strategy for utilizing their informal role as caring, helpful and sometimes frustrated individuals. The supervisors strongly indicated their need for more adequate training in the use of the program.

It was also found that supervisors have a remarkably consistent point of view. The assumption that supervisors fail to utilize the program adequately because of lack of information was clearly negated. The supervisors who were most knowledgeable about the program identified fewer problem employees and used constructive coercion less often than did naive supervisors. The need for the present study has, therefore, been well established. It is apparent that supervisors have a number of considered opinions which are strongly critical of the program concept as it has been traditionally defined. Until programs are designed to meet the needs and gain the acceptance of supervisors, they can be expected to continue to function as relatively insignficant appendages to the work place rather than as the heart of the dynamic constellation of people who comprise the community of workers.

NEED FOR FURTHER RESEARCH

As noted earlier, the present study constitutes a preliminary investigation into the factors which contribute to success or failure of employee assistance programs. Previous research has focused heavily on evaluation of program outcome on the apparent assumption that a viable program concept exists which simply requires more adequate and more extensive implementation. It has been shown, however, that many program factors need to be re-examined as the idea of employee assistance programming has obvious merit but is falling far short of its potential. Therefore, attention should be given to designing a better mousetrap (Finlay, 1978) before extensive efforts are launched to market it.

The following aspects of the program constitute primary topics for further study:

1. The treatment agency's perspective should be investigated to determine how various aspects of the program and the work place affect the employee's success in treatment. The method of motivating, quality of referral information and follow-up performance evaluation are specific areas of interest.

2. Differences in program requirements among various types of employing organizations also need to be documented. Organizations differ in size, location, composition of the work force, organizational objectives and norms, and availability of health services

and employee benefits, etc. These factors undoubtedly would affect the way in which an assistance program might be structured. Differences between business, industry, government or service organizations should be explored.

3. A comparison of American and Canadian characteristics in the work place would be a great help in determining to what extent current research can be generalized from one country to the other.

4. In addition to research directed at immediate program issues, a need has been identified for basic research into the nature of behavioral health problems and their treatment. Criticism of the disease concept of alcoholism appears to apply as well to the disease concept of behavioral health problems (and perhaps to the disease concept of disease as well if this is defined as absolving the individual from responsibility). Thus, the pragmatic emphasis of employee assistance programs may contribute a needed perspective to the broader field of mental health theory and practice.

It is important that, especially in Canada, the above concerns be explored quickly so that the findings can be utilized in the program's ongoing development. It may well be that employee assistance programs will serve as a model for a variety of health service delivery systems. However, for the present a number of serious problems need to be overcome in the basic, conceptual structure of the program.

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APPENDIX A

THE QUESTIONNAIRE

EMPLOYEE ASSISTANCE PROGRAM—SUPERVISOR'S QUESTIONNAIRE

GUIDE

The purpose of this study is to learn about the attitudes and opinions of supervisors toward various aspects of the employee assistance programs. The following guidelines are for your assistance in competing the Questionnaire.

1. Please complete every item—if you have any questions please ask the researcher for direction.
2. Sections A and B require precise factual information—please be specific.
3. Sections C, D, and E ask for your opinions and attitudes—based on your own experience. There are no right or wrong answers.
4. All information will be kept in strict confidence. Results will be reported in group form only. The completed study will be available through your employer.)

DEFINITIONS*

The following definitions apply to terms as they are used in the Questionnaire.

A. **Employee assistance program**—This is a general term which includes alcoholism programs, troubled employee programs, behavioural health programs, etc. It includes the assistance program in your own place of employment.

B. **Work performance problem**—any ongoing decline in work performance or attendance below acceptable standards or any marked decline in work performance from employee's regular or potential level.

C. **Problem employee**—is one who has work performance problems.

D. **Behavioural health problem**—any mental, emotional or physical problem (including alcoholism or drug abuse and reactions to situational stress) which may impair the individual's ability to function effectively.

E. **Immediate supervision**—you are directly responsible for maintaining work standards, evaluating performance and initiating discipline if necessary.

F. **Indirect supervision**—includes all employees reporting to supervisors who in turn report to you; or employees reporting to you in some capacity other than as line staff.

G. **Constructive Coercion**—this is a method of motivating problem employees to accept treatment. It consists of a threat of dismissal or discipline if the employee fails to accept treatment and restore work performance to an acceptable level.

H. **Regular staff**—permanent full-time employees in normal positions.

EMPLOYEE ASSISTANCE PROGRAM

SUPERVISOR'S QUESTIONNAIRE

A. PERSONAL INFORMATION

Employer ____________________ Name ____________________

Date ____________________

1. Age Range:

under 20	20-29	30-39	40-49	50-59	60 and over	Male	Female

2. Total number of years in any supervisory position ______

3. Total number of years with present employer ______

4. Are you:
   a. a member of management—no union affiliation ______
   b. a member of management but with some union affiliation ______
   c. a union member—with supervisory duties ______
   d. a supervisor with neither union nor management membership ______
   e. other (please specify) ____________________

   ____

5. Level of employees under your immediate supervision *(please indicate number of employees in each category)*.

   a. by type of work:
   - unskilled ___
   - skilled ___
   - clerical ___
   - trades ___
   - professional ___

   b. by level of position:
   - non-supervisory employees ___
   - junior supervisors, e.g., foreman ___
   - management level supervisors ___
   - senior managers ___

6. a. Do you know how to use your employer's Employee Assistance Program?

yes ___
no ___
to some extent ___

b. How did you learn about the program? *Check all that apply.*

attended a regular training session ___
read a detailed program description ___
by using it ___
heard about it indirectly ___
received a copy of the policy ___
received personal consultation (from a senior manager or program staff) ___
attended a special seminar or workshop ___
received no information ___
other *(please specify)* ______________________________
____

B. EXPERIENCE WITH EMPLOYEE PROBLEMS

Total employees supervised

1. a. Number of *regular staff** members under your *immediate supervision** at present ___

b. Number of regular staff members *indirectly** under your supervision ___

2. Total number of *regular staff** under your *immediate supervision** at some time during the past twelve months ___

Problem employees

3. Total number of employees (from #2 above) you consider to have had *work performance problems** in the past twelve months ___

**See definitions of these terms in the Questionnaire Guide (page 1).*

Questions 4-6 relate only to the problem employees identified in #3 (page 2).

4. Corrective action taken *(indicate number of employees to whom each type of action was applied--may include more than one type of action for each).* Was this action taken directly by yourself of through referral to a senior manager or personnel officer?

Action Taken	No. of Employees	Action Taken by Supervisor *(check one)*	Sr. Manager
1. No action			
2. Informal problem solving			
3. Discipline or reprimand			
4. Offer of voluntary referral for professional assistance			
5. Recommend or arrange job change			
6. Formal *constructive coercion**			
7. Immediate dismissal			

**See definitions, Questionnaire Guide (page 1).*

5. Employee response to corrective action *(complete only the relevant headings from No. 4, previous page).*

<table>
<tr><th rowspan="3">Most Intensive Supervisory Action</th><th rowspan="3">Number of Employees Involved</th><th colspan="8">Employee Response</th></tr>
<tr><th colspan="2">Offer Was</th><th colspan="2">Employee Remained and Work Performance</th><th colspan="4">OR: Employee</th></tr>
<tr><th>Accepted</th><th>Refused</th><th>Improved</th><th>Did Not Improve</th><th>Quit</th><th colspan="2">Transferred</th><th>Was Dismissed</th></tr>
<tr><td>1. No action</td><td></td><td>▨</td><td>▨</td><td></td><td></td><td></td><td colspan="2"></td><td>▨</td></tr>
<tr><td>2. Informal problem solving</td><td></td><td>▨</td><td>▨</td><td></td><td></td><td></td><td colspan="2"></td><td>▨</td></tr>
<tr><td>3. Reprimand or discipline</td><td></td><td>▨</td><td>▨</td><td></td><td></td><td></td><td colspan="2"></td><td>▨</td></tr>
<tr><td>4. Offer of voluntary referral</td><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="2"></td><td>▨</td></tr>
<tr><td>5. Recommend or arrange job change</td><td></td><td>▨</td><td>▨</td><td></td><td></td><td></td><td colspan="2"></td><td>▨</td></tr>
<tr><td>6. Constructive coercion</td><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="2"></td><td></td></tr>
<tr><td rowspan="4">7. Immediate dismissal</td><td rowspan="4"></td><td rowspan="4">▨</td><td rowspan="4">▨</td><td rowspan="4">▨</td><td rowspan="4">▨</td><td rowspan="4">▨</td><td colspan="3">Employee</td></tr>
<tr><td colspan="2">Grieved and</td><td rowspan="2">Did Not Grieve</td></tr>
<tr><td>Won</td><td>Lost</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

6. Outcome *(indicate number of employees):*

Still employed by same employer:	Work performance is:	
	Fully satisfactory	____
	Nearly satisfactory	____
	Not satisfactory	____
	Not applicable (due to extensive leave of absence, etc.)	____
No longer with employer:	Resigned	____
	Dismissed	____
	Retired	____
	Deceased	____
	Other *(please specify)*	____
	______________________	
	______________________	
	______________________	

The purpose of the following sections is to obtain your opinions and attitudes based on your own experiences and observations with regard to the employee assistance (or alcoholism) program. Please respond to every item.

C. GENERAL VIEW OF THE PROGRAM

Please rank each item in order of importance. Cross out items that are not important. (Mark most important statement as number 1; least important as 5.)

1. The proper purpose of the employee assistance program is to:

____ save money for the employer

____ help reduce illness in society

____ provide assistance to troubled employees

____ assist supervisors in effective supervision

____ improve the fairness and effectiveness of the organization

2. The program is for the benefit of:

____ society
____ the union
____ the supervisor
____ the employee
____ the employer

3. In dealing with problem employees the *supervisor* is primarily responsible to:

____ represent the employer's interest
____ protect the employee's rights
____ involve the employee in treatment
____ face the employee with his responsibilities
____ get the job done

4. Most work performance problems are due to:

____ alcoholism
____ other "behavioral health problems"*
____ the work situation
____ employee's lack of ability or training
____ inappropriate management

**See Definitions, Questionnaire Guide (page 1).*

5. In dealing with a problem employee, the supervisor's primary resource is:

____ his immediate supervisor
____ the personnel officer
____ the medical department
____ the employee assistance counsellor
____ company policy

6. The supervisor can be most helpful to problem employees by:

____ showing personal concern
____ offering referral for professional assistance
____ firm discipline
____ good supervision
____ combining a threat of dismissal with an offer to refer for treatment

7. The problem employee's motivation to accept treatment comes from:

____ confrontation by the supervisor (threat of dismissal)
____ family and social pressure
____ personal responsibility
____ situational crises
____ professional/medical information and recommendations

8. The decision to refer a problem employee for diagnosis and/or treatment *should be* the responsibility of:

____ the immediate supervisor
____ a senior manager
____ the personnel officer
____ the union steward
____ an employee assistance counsellor

9. The supervisor can initiate referrals most effectively:

____ directly
____ through the medical department of the company
____ through an employee assistance counsellor
____ through a senior manager or personnel officer
____ through a union representative or committee

10. The effectiveness of treatment depends on:

____ accessibility—quickly and readily available
____ appropriateness—suitable to the problem
____ quality of the service
____ co-ordination with the workplace
____ attendance by the employee

D. HOW THE PROGRAM WORKS

Please indicate your agreement or disagreement with the following statements by placing a check mark in the column which best expresses your opinion. Do not utilize the middle column unless absolutely necessary.

SA=Strongly Agree A=Agree I=Indifferent D=Disagree SD=Strongly Disagree

	SA	A	I	D	SD
1. A significant number of employees have behavioral health problems	___	___	___	___	___
2. These problems are costly to the employer	___	___	___	___	___
3. The employer has a right to reduce these costs by implementing an assistance program	___	___	___	___	___
4. Most of these problems are alcohol related	___	___	___	___	___
5. Threat of dismissal (constructive coercion) is effective in motivating alcoholic employees to accept treatment	___	___	___	___	___
6. Threat of dismissal is effective in motivating employees with other problems, e.g., mental illness, to accept treatment	___	___	___	___	___
7. Most problem employees are willing to accept treatment voluntarily	___	___	___	___	___
8. The work environment often plays a part in causing behavioral health problems	___	___	___	___	___
9. Poor work performance is a reliable sign of underlying behavioral health problems	___	___	___	___	___
10. Treatment is effective in resolving behavioral health problems	___	___	___	___	___
11. When such problems are effectively treated, the employee's work performance usually returns to an acceptable level	___	___	___	___	___

	SA	A	I	D	SD
12. Treatment resources in the community are readily available and accessible to the problem employee	___	___	___	___	___
13. The Union's role tends to conflict with the assistance program	___	___	___	___	___
14. Union/management cooperation is needed for program success	___	___	___	___	___
15. You have adequate support from senior management in utilizing the assistance program	___	___	___	___	___
16. When faced with a difficult employee problem, you have adequate consultation available from a qualified professional	___	___	___	___	___
17. The problem employee's rehabilitation program should involve cooperation between the treatment agency and the work place	___	___	___	___	___
18. Treatment agencies work closely with you to help problem employees (i.e., obtain relevant information from you and give you useful feedback)	___	___	___	___	___
19. An effective assistance program needs to provide diagnostic and referral services—as a link between the work place and the treatment agency	___	___	___	___	___
20. Behavioral health problems, such as alcoholism, are illnesses	___	___	___	___	___
21. Adequate sickness benefits are provided for employees with behavioral health problems	___	___	___	___	___
22. The supervisor has a right to expect problem employees to accept referral for diagnosis and treatment	___	___	___	___	___
23. Failure to overcome poor work performance should result in discipline or dismissal	___	___	___	___	___

	SA	A	I	D	SD
24. The employee can be guaranteed that cooperation with the program will not affect his job security or opportunities for advancement					
25. The supervisor should be concerned only with the work performance of the problem employee					
26. The program adequately protects the employee's confidentiality					
27. The program limits your right to enforce standard personnel policy					
28. It is the employee's responsibility to seek help on his own when he first develops a behavioral health problem					
29. Adequate training is provided to supervisors concerning the assistance program					

E. THE SUPERVISOR'S ROLE

1. Employees who are not performing adequately on the job usually have behavioral health problems					
2. Existing performance standards are fair and clear					
3. Many incidents of poor work performance can best be handled without formal documentation					
4. The supervisor is in the best position to identify employees who may have behavioral health problems					
5. The supervisor is contributing to the employee's problem if he fails to identify and confront the problem employee					

	SA	A	I	D	SD
6. You usually know *why* an employee is performing poorly on the job	___	___	___	___	___
7. Identification of problem employees is always in the employee's best interests	___	___	___	___	___
8. Problem employees should be identified at the earliest possible stage	___	___	___	___	___
9. Involvement in the assistance program is in the best interests of the problem employee	___	___	___	___	___
10. You have the necessary authority to motivate most problem employees to accept treatment by threatening to dismiss them (constructive coercion).	___	___	___	___	___
11. This (No. 10) is a proper part of your job	___	___	___	___	___
12. Constructive coercion is in the best interests of the problem employee	___	___	___	___	___
13. The use of constructive coercion is likely to disrupt the working relationship between the supervisor and the employee	___	___	___	___	___
14. Senior management will support the supervisor if the employee disputes or grieves his action	___	___	___	___	___
15. Constructive coercion carries the risk that the employee will be harmed rather than helped	___	___	___	___	___
16. You are in a position to select an appropriate treatment agency for the problem employee	___	___	___	___	___
17. Coordination between the work place and the treatment agency is important	___	___	___	___	___
18. You have adequate input to the treatment agency	___	___	___	___	___

	SA	A	I	D	SD
19. You receive adequate feedback from the treatment agency	___	___	___	___	___
20. Many problems tend to resolve themselves without treatment	___	___	___	___	___
21. The effectiveness of treatment is reduced in cases where the client has been coerced to accept treatment	___	___	___	___	___

ADDITIONAL COMMENTS

APPENDIX B

MEAN VALUES FOR RANK ORDER TABLES

Table A

The Supervisor's View of Program Philosophy
(Mean Value of Ranks Assigned)

	Employer							
Item	RPW	AGS	EDM	LAB	CNR	AGT	Total	No Response*
			Purpose of Program					
Program purpose is to:								
Assist employees	1.3	1.6	1.9	1.5	1.8	1.3	1.6	0
Assist supervisors	2.5	2.7	2.6	3.0	3.1	3.0	2.8	4
Improve organization	2.5	3.1	2.8	3.0	2.9	3.4	3.0	4
Reduce illness	4.3	3.5	3.6	3.3	3.4	3.5	3.6	14
Save money	4.1	3.7	4.0	3.6	3.5	3.5	3.7	16
Program Benefits:								
Employee	1.2	1.4	1.3	1.1	1.3	1.3	1.3	0
Employer	2.3	2.3	2.4	2.5	2.3	2.3	2.4	2
Supervisor	2.6	2.8	2.5	3.1	3.4	3.1	2.9	5
Society	4.1	3.7	4.0	3.5	3.2	3.5	3.7	9
Union	4.6	4.6	4.6	4.5	4.7	4.8	4.6	29
			Program Concept					
Poor Work Performance is Due to:								
Other behavioral health problems	2.8	2.4	2.6	2.2	2.5	2.0	2.4	3
Work situation	2.1	3.4	2.9	2.6	2.9	2.4	2.7	9
Lack of ability/training	2.8	2.6	2.5	3.5	2.5	2.6	2.7	10
Alcoholism	3.4	2.2	3.2	3.5	2.8	4.4	3.2	8
Inappropriate management	3.4	4.0	3.3	3.0	4.1	3.6	3.6	17
Source of Motivation:								
Personal responsibility	2.6	2.7	2.5	2.7	2.9	2.3	2.6	6
Family & social pressure	3.0	2.9	2.8	2.3	3.1	2.8	2.8	5
Situational crises	2.7	3.0	3.4	2.7	3.0	3.1	3.0	9
Confrontation by supervisor	3.3	2.8	2.8	3.6	2.7	3.0	3.0	8
Professional/medical information	3.2	3.0	3.1	3.5	3.1	3.4	3.2	5
Treatment effectiveness depends on:								
Attendance by employee	2.5	2.2	1.7	1.8	1.8	1.7	1.9	5
Appropriateness	2.0	2.8	2.6	2.8	2.9	3.0	2.7	4
Accessibility	2.9	2.9	3.1	2.8	2.8	3.1	2.9	4
Quality of service	3.3	3.2	3.2	3.0	3.1	2.8	3.1	6
Coordination with work place	4.2	3.7	4.3	4.1	4.0	4.3	4.1	17

*Participants were instructed to leave an item blank if it was not important at all. However, these non-responses were not included in the calculation as they would not have significantly altered the rank order of items.

Table B

The Supervisor's Role in the Program
(Mean Value of Ranks Assigned)

	Employer							
Item	RPW	AGS	EDM	LAB	CNR	AGT	Total	No Answer*
Supervisor's responsibility is to:								
Face employee with his responsibility	2.5	2.6	2.1	1.8	2.4	2.3	2.3	2
Involve employee in treatment	2.6	2.3	3.0	2.4	3.0	2.8	2.7	1
Represent employer	3.0	2.7	2.3	3.2	2.5	2.4	2.7	1
Get the job done	2.9	3.7	3.1	3.4	3.2	3.8	3.4	12
Protect employee rights	3.3	3.4	4.3	3.8	3.7	3.7	3.7	14
Supervisor's prime resource is:								
His supervisor	1.6	1.6	1.4	1.6	1.5	1.2	1.5	3
Program counselor	2.5	2.7	2.9	3.8	3.0	3.6	3.0	18
Personnel officer	3.0	2.9	3.9	2.8	2.6	4.1	3.2	18
Company policy	3.2	3.9	2.7	3.4	3.4	2.9	3.2	14
Medical department	4.2	3.7	3.5	3.0	3.7	2.8	3.5	14
Supervisor helps employee most by:								
Showing personal concern	2.1	1.6	2.0	1.9	1.8	1.7	1.8	2
Good supervision	1.5	3.0	3.0	2.1	2.2	2.2	2.4	4
Offering professional referral	2.9	2.2	2.3	3.0	2.8	2.7	2.6	2
Firm discipline	3.6	3.9	3.6	3.5	3.6	3.8	3.7	10
Constructive coercion	4.5	4.2	4.0	4.3	4.4	4.5	4.3	14
Decision to refer should be made by:								
Immediate supervisor	2.4	1.8	2.1	2.0	1.9	1.2	1.9	12
Program counselor	1.9	2.4	2.1	2.5	2.3	2.7	2.3	11
Senior manager	2.6	2.4	2.9	3.2	2.5	2.2	2.6	12
Personnel officer	3.3	3.4	2.9	2.7	3.8	4.2	3.4	28
Union steward	4.3	4.5	4.4	3.8	4.0	4.3	4.2	41
Supervisor can refer most effectively:								
via Program counselor	1.7	2.1	2.1	2.3	2.1	2.9	2.2	11
via Manager or personnel	2.3	2.5	2.3	2.9	2.4	2.2	2.4	7
via Medical department	2.9	2.8	2.8	2.1	2.8	1.7	2.5	11
Directly	3.4	2.9	3.1	3.1	3.2	3.0	3.1	25
via Union representative	3.8	4.1	4.1	3.8	3.8	4.7	4.1	36

*See footnote Table 14.

Table C

Program Philosophy

Comparison by Age
(mean Value of Ranks Assigned)

Item	Age < 40	 ⩾ 40
PURPOSE OF PROGRAM		
Program purpose is to:		
Assist employees	1.6	1.6
Assist supervisors	2.9	2.9
Improve organization	3.0	3.1
Reduce illness	4.0	3.7
Save money	3.9	4.0
Program Benefits:		
Employee	1.3	1.3
Employer	2.4	2.4
Supervisor	3.0	3.1
Society	3.9	3.7
Union	4.9	4.9
PROGRAM CONCEPT		
Poor Work Performance is Due to:		
Other behavioral health problems	2.6	2.4
Work situation	2.8	3.1
Lack of ability/training	2.9	3.0
Alcoholism	3.6	3.1
Inappropriate management	3.8	3.9
Source of Motivation:		
Personal responsibility	2.9	2.6
Family & social pressure	2.9	2.9
Situational crises	3.2	3.2
Confrontation by supervisor	2.9	3.4
Professional/medical information	3.4	3.3
Treatment Effectiveness Depends On:		
Attendance by employee	2.3	1.9
Appropriateness	2.7	2.8
Accessibility	3.0	3.0
Quality of service	3.2	3.2
Coordination with work place	4.0	4.5

Note: Order of items reflects rank order for total group (see Table 14).

Table D

The Supervisor's Role in the Program

Comparison by Age
(Mean Value of Ranks Assigned)

Item	<40	≥40
Supervisor's responsibility is to:		
Face employee with his responsibility	2.3	2.3
Involve employee in treatment	2.8	2.7
Represent employer	2.5	2.9
Get the job done	3.8	3.5
Protect employee rights	3.9	4.0
Supervisor's prime resource is:		
His supervisor	1.5	1.7
Program counselor	3.2	3.6
Personnel officer	3.7	3.4
Company policy	3.5	3.5
Medical department	3.9	3.5
Supervisor helps employee most by:		
Showing personal concern	2.2	1.7
Good supervision	2.4	2.5
Offering professional referral	2.7	2.7
Firm discipline	3.8	3.9
Constructive coercion	4.3	4.6
Decision to refer should be made by:		
Immediate supervisor	2.2	2.3
Program counselor	2.3	2.8
Senior manager	2.9	2.9
Personnel officer	3.9	3.9
Union steward	4.9	4.6
Supervisor can refer most effectively:		
via Program counselor	2.3	2.6
via Manager or personnel	2.5	2.7
via Medical department	3.0	2.6
Directly	3.4	3.8
via Union representative	4.5	4.6

Note: Order of items reflects rank order for total group (see Table 14).

Table E

Program Philosophy

Comparison by Sex
(Mean Value of Ranks Assigned)

Item	Male	Female
PURPOSE OF PROGRAM		
Program Purpose is to:		
Assist employees	1.6	1.1
Assist supervisors	2.9	3.2
Improve organization	3.1	2.9
Reduce illness	3.8	3.8
Save money	3.9	4.2
Program Benefits:		
Employee	1.3	1.1
Employer	2.4	2.4
Supervisor	3.1	2.8
Society	3.8	4.1
Union	4.9	5.1
PROGRAM CONCEPT		
Poor Work Performance is Due to:		
Other behavioral health problems	2.6	1.9
Work situation	3.0	2.3
Lack of ability/training	3.0	2.6
Alcoholism	3.2	4.7
Inappropriate management	3.8	4.1
Source of Motivation:		
Personal responsibility	2.9	2.1
Family & social pressure	2.9	3.1
Situational crises	3.2	3.0
Confrontation by supervisor	3.1	3.6
Professional/medical information	3.3	3.4
Treatment Effectiveness Depends On:		
Attendance by employee	2.1	2.0
Appropriateness	2.7	2.9
Accessibility	3.0	3.0
Quality of service	3.3	3.0
Coordination with work place	4.3	4.6

Note: Order of items reflects rank order for total group (see Table 14).

Table F

The Supervisor's Role in the Program

Comparison by Sex
(Mean Value of Ranks Assigned)

Item	Male	Female
Supervisor's responsibility is to:		
Face employee with his responsibility	2.4	2.1
Involve employee in treatment	2.7	2.7
Represent employer	2.7	3.0
Get the job done	3.6	3.7
Protect employee rights	4.0	3.6
Supervisor's prime resource is:		
His supervisor	1.6	1.4
Program counselor	3.4	3.3
Personnel officer	3.5	3.9
Company policy	3.4	4.2
Medical department	3.8	3.4
Supervisor helps employee most by:		
Showing personal concern	1.8	2.4
Good supervision	2.5	2.1
Offering professional referral	2.7	2.7
Firm discipline	3.9	3.2
Constructive coercion	4.4	4.9
Decision to refer should be made by:		
Immediate supervisor	2.3	2.0
Program counselor	2.6	2.3
Senior manager	2.9	2.8
Personnel officer	3.8	4.3
Union steward	4.7	5.0
Supervisor can refer most effectively:		
via Program counselor	2.5	2.3
via Manager or personnel	2.6	2.6
via Medical department	2.9	2.2
Directly	3.6	3.7
via Union representative	4.5	5.1

Note: Order of items reflects rank order for total group (see Table 14).

Table G
Program Philosophy

Comparison by Knowledge of Program
(Mean Value of Ranks Assigned)

Item	Know	Don't Know	Know to Some Extent
PURPOSE OF PROGRAM			
Program Purpose is to:			
Assist employees	1.5	1.8	1.5
Assist supervisors	2.9	2.7	3.0
Improve organization	3.2	2.7	3.1
Reduce illness	3.6	4.0	3.9
Save money	4.1	4.1	3.8
Program Benefits:			
Employee	1.2	1.3	1.3
Employer	2.6	2.5	2.2
Supervisor	3.0	2.8	3.1
Society	3.7	3.8	3.8
Union	5.0	5.1	4.8
PROGRAM CONCEPT			
Poor Work Performance is Due to:			
Other behavioral health problems	2.5	2.4	2.5
Work situation	2.7	2.8	3.0
Lack of ability/training	3.4	2.7	2.8
Alcoholism	3.2	3.4	3.4
Inappropriate management	3.8	3.9	3.8
Source of Motivation:			
Personal responsibility	3.4	2.0	2.7
Family & social pressure	3.1	2.8	2.9
Situational crises	2.9	3.3	3.3
Confrontation by supervisor	2.7	3.8	3.3
Professional/medical information	3.2	3.4	3.2
Treatment Effectiveness Depends On:			
Attendance by employee	2.5	2.2	1.8
Appropriateness	2.7	2.7	2.8
Accessibility	2.8	2.8	3.2
Quality of service	3.1	3.4	3.3
Coordination with work place	4.3	4.2	4.4

Note: Order of items reflects rank order for total group (see Table 14).

Table H

The Supervisor's Role in the Program

Comparison by Knowledge of Program
(Mean Value of Ranks Assigned)

Item	Know	Don't Know	Know to Some Extent
Supervisor's responsibility is to:			
Face employee with his responsibility	2.1	2.4	2.4
Involve employee in treatment	2.6	2.7	2.7
Represent employer	2.9	2.9	2.4
Get the job done	3.4	3.5	3.7
Protect employee rights	4.2	3.7	4.0
Supervisor's prime resource is:			
His supervisor	1.7	1.7	1.5
Program counselor	3.5	2.9	3.6
Personnel officer	3.5	3.2	3.7
Company policy	3.5	3.8	3.3
Medical department	3.3	4.2	3.7
Supervisor helps employee most by:			
Showing personal concern	1.7	1.9	1.9
Good supervision	2.7	2.2	2.3
Offering professional referral	2.6	2.9	2.7
Firm discipline	4.0	3.5	3.8
Constructive coercion	4.1	4.5	4.7
Decision to refer should be made by:			
Immediate supervisor	2.2	2.2	2.2
Program counselor	2.9	2.5	2.5
Senior manager	3.2	2.9	2.8
Personnel officer	4.2	3.2	4.0
Union steward	4.8	4.7	4.6
Supervisor can refer most effectively:			
via Program counselor	2.8	2.2	2.5
via Manager or personnel	2.6	2.6	2.6
via Medical department	2.3	3.0	2.8
Directly	3.7	3.6	3.6
via Union representative	4.6	4.5	4.5

Note: Order of items reflects rank order for total group (see Table 14).

Table I

Program Philosophy

Comparison by Managerial Affiliation (Mean Value of Ranks Assigned)

Item	Managers	Union Members
PURPOSE OF PROGRAM		
Program Purpose is to:		
Assist employees	1.5	.8
Assist supervisors	2.9	2.7
Improve organization	3.2	2.8
Reduce illness	3.8	4.0
Save money	3.9	3.9
Program Benefits:		
Employee	1.2	1.4
Employer	2.4	2.3
Supervisor	3.2	2.7
Society	3.6	4.1
Union	4.8	5.0
PROGRAM CONCEPT		
Poor Work Performance is Due to:		
Other behavioral health problems	2.4	2.6
Work situation	2.9	3.0
Lack of ability/training	2.9	2.9
Alcoholism	3.5	3.0
Inappropriate management	3.9	4.1
Source of Motivation:		
Personal responsibility	2.9	2.6
Family & social pressure	2.9	3.1
Situational crises	3.0	3.4
Confrontation by supervisor	3.2	3.3
Professional/medical information	3.4	3.2
Treatment Effectiveness Depends On:		
Attendance by employee	2.0	2.3
Appropriateness	2.9	2.7
Accessibility	2.9	3.0
Quality of service	3.3	3.1
Coordination with work place	4.3	4.1

Note: Order of items reflects rank order for total group (see Table 14).

Table J

The Supervisor's Role in the Program

Comparison by Management Affiliation
(Mean Value of Ranks Assigned)

Item	Managers	Union Members
Supervisor's responsibility is to:		
Face employee with his responsibility	2.3	2.6
Involve employee in treatment	2.6	2.9
Represent employer	2.6	2.7
Get the job done	3.5	3.5
Protect employee rights	4.1	3.7
Supervisor's prime resource is:		
His supervisor	1.6	1.5
Program counselor	3.5	3.2
Personnel officer	3.6	3.2
Company policy	3.3	3.8
Medical department	3.5	4.2
Supervisor helps employee most by:		
Showing personal concern	2.0	1.8
Good supervision	2.5	2.5
Offering professional referral	2.6	2.8
Firm discipline	3.8	3.8
Constructive coercion	4.3	4.6
Decision to refer should be made by:		
Immediate supervisor	2.2	2.2
Program counselor	2.7	2.4
Senior manager	2.9	2.7
Personnel officer	4.0	3.6
Union steward	4.7	4.8
Supervisor can refer most effectively:		
via Program counselor	2.6	2.2
via Manager or personnel	2.5	2.5
via Medical department	2.7	3.0
Directly	3.7	3.6
via Union representative	4.5	4.5

Note: Order of items reflects rank order for total group (see Table 14).

Table K

Program Philosophy

Comparison by Level of Position
(Mean Value of Ranks Assigned)

Item	Senior Supervisors	Junior Supervisors
PURPOSE OF PROGRAM		
Program Purpose is to:		
Assist employees	1.6	1.5
Assist supervisors	2.9	3.0
Improve organization	2.9	3.2
Reduce illness	4.0	3.6
Save money	3.9	4.0
Program Benefits:		
Employee	1.2	1.3
Employer	2.4	2.4
Supervisor	3.1	3.0
Society	3.9	3.7
Union	4.9	4.9
PROGRAM CONCEPT		
Poor Work Performance is Due to:		
Other behavioral health problems	2.4	2.6
Work situation	2.8	3.0
Lack of ability/training	3.0	3.0
Alcoholism	4.0	3.2
Inappropriate management	4.0	3.8
Source of Motivation:		
Personal responsibility	2.8	2.7
Family & social pressure	3.0	2.9
Situational crises	3.0	3.4
Confrontation by supervisor	3.5	2.9
Professional/medical information	3.2	3.4
Treatment Effectiveness Depends On:		
Attendance by employee	2.1	2.0
Appropriateness	2.7	2.8
Accessibility	3.0	3.0
Quality of service	3.2	3.3
Coordination with work place	4.3	4.3

Note: Order of items reflects rank order for total group (See Table 14).

Table L

The Supervisor's Role in the Program

Comparison by Level of Position
(Mean Value of Ranks Assigned)

Item	Senior Supervisors	Junior Supervisors
Supervisor's responsibility is to:		
Face employee with his responsibility	2.4	2.3
Involve employee in treatment	2.8	2.6
Represent employer	2.7	2.7
Get the job done	3.5	3.7
Protect employee rights	3.9	3.9
Supervisor's prime resource is:		
His supervisor	1.6	1.5
Program counselor	3.2	3.6
Personnel officer	3.6	3.5
Company policy	3.7	3.2
Medical department	3.5	3.9
Supervisor helps employee most by:		
Showing personal concern	1.8	2.0
Good supervision	2.4	2.5
Offering professional referral	2.6	2.7
Firm discipline	3.9	3.7
Constructive coercion	4.4	4.5
Decision to refer should be made by:		
Immediate supervisor	2.2	2.3
Program counselor	2.6	2.6
Senior manager	3.1	2.7
Personnel officer	4.1	3.6
Union steward	4.7	4.7
Supervisor can refer most effectively:		
via Program counselor	2.5	2.5
via Manager or personnel	2.7	2.4
via Medical department	2.8	2.8
Directly	3.5	3.7
via Union representative	4.6	4.4

Note: Order of items reflects rank order for total group (see Table 14).

APPENDIX C

INTERVIEW SUMMARIES

Interview No. 1

Program Rationale

Need for Program

The employer has a moral responsibility to provide help. The problems are varied but most work performance problems are work related rather than health related. Underlying reasons for work performance problems include–

1. Workers earn too much money and consequently a low motivation for work.
2. There is insufficient incentive for good performance because merit and experience are not rewarded with increased pay. It is noted that work performance problems decrease when jobs are scarce. Behavioral health problems are a smaller problem than are social and economic factors. Many behavioral health problems arise because *"we can't cope with the amount of free time we have."*

Method of Motivation

The present demerit system is *"antiquated"* and does not work. (Discipline consists of assessing demerit points. 60 demerits result in automatic dismissal.) It is conceded that a high number of demerit points often lead to a positive change in the employee. However, discipline needs to affect the pocket book. In addition, the collective agreement restricts many useful options for dealing with performance problems. The concept of constructive coercion is used but not endorsed. *"Any time you force a man to do something, I'm not too sure anybody wins."* Constructive coercion is risky because the outcome is unpredictable and is an unpleasant task for the supervisor. Motivation is considered to be the employee's responsibility. *"There's nothing you can do if he's not prepared himself."*

Referral Process

Treatment is seen as quite separate from the work situation, e.g., does not know if coordination with the work place is important or not. It seems the supervisor has little involvement in the decision to refer for treatment.

Supervisor's Role

The supervisor is considered to owe the employee some sort of assistance. However, the program gives the supervisor no feedback, direction or help, i.e., should give the supervisor the knowledge he requires to deal with the problem and to detect problems early.

Identification

Does not know how to intervene early because alcoholics are devious. There is something lacking in the program with regard to catching people early and motivating them. Safety problems are not a good indicator. The supervisor needs to diagnose the alcohol problem–otherwise the matter is dealt with on a disciplinary basis.

Interview No. 1, continued

Motivation

Drinking on the job leads to automatic dismissal in the running trades (Rule G). A suspected alcoholic may be referred to the company doctor but he can refuse the referral. *"You can't force somebody into treatment if they don't want it."* If the employee denies being alcoholic, the supervisor looks like a *"dummy"* and the employee simply goes back to work. The supervisor *"does not work that much with the doctor."*

Referral

The supervisor has very little involvement with the doctor or the program. He may be notified if the employee is placed on sick leave. There is no coordination between the supervisor and the treatment agency.

The supervisor may recommend that the employee see the doctor. If the employee is found to be alcoholic, the doctor refers him to the counsellor who, in turn, refers him to AADAC. The counsellor is not helpful to the supervisor initially because of his distance from the scene.

Example

A five-year employee who was a good worker at first but increasingly comes in late and books off a lot is still a good worker when working. The problem has occurred off and on for five years. The supervisor has no information concerning his previous work record.

Employee was called in for disciplinary interviews and asked the reason for his problem. (Supervisor notes he does not have the right to ask this.) He recently learned that the employee has a business of his own which is affecting his attendance on this job.

It is expected that the employee will quit and *"we won't have to fire him."*

(J. is in his forties and has been with CNR for 27 years. He has a son who abuses drugs and alcohol and has been in prison. He seems angry, frustrated and bitter about his son but feels this experience has not affected his view of the program. He does not believe the program has anything to offer him in dealing with his own stress.)

Interview No. 2

J. is an Officer 5 in the Fish and Wildlife Branch. He has been with the Alberta Government for 13 years.

Need for Program

The purpose of the program from the employer's point of view is to save money. However, J. would like to think the employer wants to help the employee as well. This is especially possible in government because it is not production oriented. Helping employees does save money.

Most work performance problems are due to lack of training or ability or lack of suitability to the job. Behavioral health problems account for a minimal proportion of all poor work performance, e.g., an officer who feels physically ill when required to write a ticket is considered unsuitable for this type of job.

The supervisor should not be concerned (officially) with personal problems of his staff unless work performance is affected.

Method of Motivation

Regarding constructive coercion—*"I don't buy that at all."* The supervisor can force the employee to go for help, but treatment will not be effective unless he is personally motivated. *"I got to make that guy go to the doctor because he wants to go to the doctor . . . I've got to convince him that that's the thing to do."* J. distinguishes between getting the employee to take treatment and accepting treatment. The supervisor should take responsibility for generating this level of motivation. *"That's what I get paid for."* e.g., supervisor may place alcoholic employee with a recovered alcoholic and encourage informal counselling. Motivation of a problem employee is *"ify"* and the supervisor must play it by ear.

The supervisor cannot expect the employee to recognize he has a problem or acknowledge he needs help. A considerable stigma is attached to mental problems and must be counteracted by the supervisor.

Referral Process

The supervisor may treat the problem himself through counselling, situational intervention or expression of personal concern. However, he should have a source of consultation so he can outline the problem and obtain advice.

"When I have a problem I can't handle I start looking around," i.e. for treatment resources. J. does not know to whom he could refer but has heard of the Diagnostic and Referral Unit and would rely on a senior manager to provide information concerning suitable resources and how to utilize them. J. knows that employees often resolve their own problems. The decision to refer should be made jointly by the supervisor and the counsellor and carried out only with the full cooperation of the employee. Advice from the treatment resource would be utilized only if he considered it appropriate.

Treatment Effectiveness

J. wants to be part of the treatment process and would like feedback from the doctor regarding the employee's competence, signs of relapse, etc. He does not believe that treatment is totally effective—if they require long term rehabilitation and there may be a danger of relapse. J. considers treatment very complex—a matter of degree, e.g., like repairing a boot—I need somebody that I have some confidence in to say *"We resoled that guy for you."*

Interview No. 2, continued

Role of the Supervisor

Wildlife officers gain increasing management responsibility through all five levels. J. is a union member with supervisory duties. This has advantages and disadvantages. For example, this results in closer identification with the workers and J. likes to be "one of the guys". However, on occasion he is not allowed to review a file which he has written. His primary loyalty is to the resource–not to management or the worker.

J. feels he gets reasonable support from senior management in dealing with problem employees. The program is a positive thing but should be more widely publicized. A primary advantage of the program is that it provides consultation to the supervisor. J. notes that most supervisors would probably not agree with his own view of the supervisor's responsibility toward his employees.

Interview No. 3

Supervisor of Carload Operations–Servo Center. H. is one of seven supervisors responsible for 190 staff. The center handles all paper flow and computer records regarding location of railroad cars. He is in his thirties and has been with CN for 12 years, 4 as a supervisor. Describes himself as haywire as a kid–has worked hard and gotten stung sometimes.

Need for Program

Behavioral health problems are very rare. An employee can do well if he wants to. Society is responsible for most work performance problems, i.e., expectation for good pay for little work. The seniority system is *"bull-shit"*–employees should be paid for performance.

Re problem employees–some people just don't click. This indicates they are in the wrong job. There are no dumb people. Poor work performance is not a disease and employees do not need special attention. However, some employees are *"homers"* and refuse to leave a job although they are not succeeding. Young kids are typically haywire and tend to straighten out in time. A prime problem is one of attitude. These are *"rotten apples"* who do not fit into the job.

"When people have problems you can pick them up pretty fast," i.e. through computer errors, etc. However, a pattern of performance is difficut to establish because of inconsistent supervision and lack of continuity between shifts.

Method of Motivation

"Unions are too damn strong"–we can't do anything. The demerit system is too structured and assessment of demerits has little effect. The problem employee's peers tend to carry him for a while and then complain to the supervisor. Most needs to be forced to accept responsibility. The supervisor gets involved only when the problem affects the job. If the employee does not fit in the supervisor attempts to get him out; i.e., obtain his resignation. This represents a positive opportunity for the employee to obtain a new job. H. feels OK in taking this action. However, *"there are real assholes in this world and you've got to live with them."*

If the employee is emotionally disturbed the supervisor has to approach him in the right way. H. emphasizes the need for the supervisor to be skillful in handling each individual case.

Referral for Treatment

H. concedes that poor workers may be suffering from behavioral health problems. If this is suspected they should be tested (does not know what kind of assessment is possible). This situation has not occurred.

Treatment consists of counselling by the supervisor. He is open to discuss problems if the employee wants to–but they usually don't. Constructive coercion is fair if the supervisor has diagnosed the problem and determined the need for help.

H. believes the alcoholism program is a good one but notes he never had any training on how to handle these employees.

Example of Problem Employee

Young employee with poor work history exhibited absenteeism, sloppiness, failure to follow instructions, lateness, etc. He did not want to better himself. Brought his girlfriend to work (she was better at his job than he was). Supervisor has talked to him, spelled out expectations, assigned him to a different job and provided extra training. The next step is to have a senior manager assess demerits and confront him with shaping up or shipping out. His problem is that he's in the wrong job.

On the next incident he will be talked to for the fourth time and an investigation will result in demerits (he already has ten). Eventually, he will either improve his attitude or leave. H. predicts he won't come around.

H. has had two problem employees, one hospitalized in Alberta Hospital and one at Henwood. He assisted in rescuing one from a suicide attempt but later had to dismiss him.

Interview No. 4

Fifty to sixty years of age, 26-year employee of the province. Planning to accept early retirement shortly. Supervises two small shops employing tradesmen.

Example of Problem Employee

The Problem

This employee had been a problem for many years, i.e., well before he came under C.'s supervision seven years ago. His previous supervisor *"just didn't bother with him"* as he considered him hopeless (was working as a paint shop supervisor). He was sometimes fine and sometimes very uptight for no reason. He believed no one else deserved their job. Rejected supervisor's authority and generally refused to go along with instructions. Thought he was being spied on by his supervisor.

Method

Employee was given a bad annual rating and improved somewhat the next year. C. tried to involve him in supervisory meetings and gave him extra responsibility which he rejected. Basic approach was to try reasoning with him and provide helpful information. When he did not respond C. recommended he be transferred to another area but this was not done. The problem was referred to senior management and subsequently was primarily supervised by the senior manager, bypassing C.

C. notes that he does not know what was wrong with the employee. Thinks he would have done better with less supervisory responsibility. He notes that the problem was more than just job pressure *"but I'm no doctor"* therefore cannot say what was wrong. C. believes there may have been some sort of personal problem but notes that he has been very fair to the employee. Questions whether he may have been responsible for the man's performance problems. Did not recommend to the employee that he seek treatment because this is risky. C. imagines he would have complained to the Minister. (C. notes the employee had 83 days of sick leave last year.) C. notes that such problems are OK if you can talk to the man but if not, you have to get rid of him.

Outcome

The employee is now being placed on long-term disability benefits as he has been away from work over sixty days. He gathers the employee will not be returning to work. The position is still being held open. C. does not know how the man is doing but he sounded OK on the phone last time he talked to him.

Problem Employee Example No. 2

Problem

This was an alcoholic employee–a man you could talk to. He tended to be very up tight, often missed days and was undependable. He told lots of (untrue) stories.

Method

C. talked to him often. Persuaded him to start attending AA again. Also counselled him about more appropriate living arrangements and separating from old drinking buddies.

The employee had gotten involved with the member counselling unit somehow. He was on *Antabuse* and this was supervised by a co-worker on the job. C. was worried that the *Antabuse* might prohibit him from operating machinery as his mind appeared fogged and he lacked coordination. (Side effects of *Antabuse* were never explained.)

At one point the employee was hospitalized at AHE for depression. C. phoned the doctor and discovered that the employee had claimed to have abstained from alcohol since the previous Fall. He advised the doctor that this was not true.

Outcome

The employee had to be dismissed for his own good. C. heard of a job at Alberta Hospital and tried to arrange a transfer but this was not accepted by the hospital. At one point the employee had been absent from work for quite a while. C. advised him to get a job with less contact with co-workers and make some new friends. He recommended the man take up dancing for recreation. Ultimately, the man was given a choice of termination or resignation. He requested termination in order to qualify more quickly for welfare benefits. C. does not know where he is now.

Program Rationale

C. believes constructive coercion is in the best interests of the employee when it works but it may backfire. He does not know if the risk is worth while. The use of constructive coercion is a matter of judgment in each individual case. C. believes that coercion tends to decrease the effectiveness of treatment.

C. feels comfortable in selecting a treatment agency as he is aware of the member counselling unit and AA. He tries to convince employees to go voluntarily, i.e., completely apart from any involvement by the work place. He feels a professional counsellor is more able to involve the entire family.

C. expressed concerns about his own adequacy in dealing with these problems. He showed little recognition of the nature of the assistance program and feels that when the supervisor fails to correct a problem the employee should be gotten rid of. (However he seems to rely heavily on the employee's willingness to leave.)

Interview No. 5

Supply and equipment (shipping and receiving) supervisor. 9 years' experience as a supervisor, 5 with present employer. Twenty to thirty years old—is responsible for two staff.

Example of Problem Employee

Problem

This employee does good work and can be excellent at her job. The problem is in how she relates to her supervisor and the branch. She is habitually late and her attitude is *"I'll do as I please—I'm doing a good job."* She does not accept correction and is insubordinate. The problem has been going on for three years, i.e., since D. assumed supervision and she reportedly had problems previously. D. notes that she leads a carefree life style. He notes that he still does not know what the basic problem is . . . *"can you imagine that."*

Method

D. keeps a personal file documenting problem behavior and this is reflected in the annual rating. He has discussed the matter with his senior manager who advises that he keep on coping as best he can. i.e., follow the middle of the road between toughness and flexibility—avoid confrontation.

D. sees the employee as having good technical skills but poor personal and attitudinal skills. She may have a health problem as she seems to stay up too late at night.

Outcome

The problem is ongoing. D. expects to continue with his present strategy which he admits is not working well and is placing him under a high degree of stress.

Program Rationale

D. tries not to be too heavy on documentation as this may work against the employee. He documents specific problems on a scan file and keeps his own superior fully informed. He feels the program should improve the fairness of the organization and the effectiveness of the supervisor.

D. is maintaining the status quo because he wants to give the employee a chance. He is afraid senior management may come down harder on her than he wants them to if he refers the problem to them for action. He is also afraid that documentation and disciplinary action may cause the problem to deteriorate. This may reflect on himself as a supervisor. He notes that the supervisor risks his credibility in identifying problems and initiating action. His senior manager has not encouraged D. to involve himself in the problem. His attitude is *"Let's try to avert any confrontation."* i.e., this would mean that the situation is no longer tolerable. D. notes that a confrontation would put his own credibility on the line and he must be sure of his basis for disciplinary action.

D. notes that there seems to be a personality conflict and questions whether he is partly at fault. He notes that the ongoing situation adversely affects his own performance. When asked "At what point do you decide it's got to come to a head?" he replied, *"Shucks, I don't know."* D. agrees that he has lost the initiative in this situation and the problem employee controls the situation. He notes *"I should have taken the upper hand sooner."*

Interview No. 5, continued

D. believes the supervisor has little influence in motivating the employee to accept treatment. He stresses that commitment to the job is the important factor in modifying the employee's behavior or persuading her to accept help. However, D. notes that on-the-job education and appropriate placement are more important than treatment. He sees treatment as having only a minimal influence on employee behavior.

D. is a union member in a supervisory role. He is more loyal to the employer because *"they are the people that feed me."* His union membership causes no conflict because he is not "union oriented". D. denies any concern over his own competence.

Interview No. 6

Grounds Foreman–NAIT, in thirties, eighteen years' supervisory experience but *"new to the Government"* i.e. two years. Previous experience was with CPR. Union membership does not make any difference as he represents the employer.

Need for Program

L. believes *"a happy employee is a productive employee."* Therefore saving money and helping the employee are compatible goals. However, the company is more interested in saving money whereas the supervisor feels a personal, moral obligation to help if the employee asks. If the employee resists help the supervisor must primarily represent the employer. L. estimates that 10–20% of employees are alcoholic. He believes supervisors generally tend to feel that you don't have to work as hard in government as in private industry.

Method of Motivation

Being someone's boss does not mean you can help him do his job better. The problem employee needs to devekope pride in his work. As his supervisor, you teach him everything you can and hope he gains insight. If he refuses to produce, you have to let him go. i.e., the problem won't go away by itself–therefore if he does not ask for help your only option is termination.

The supervisor has to diagnose the problem before taking action. L. does not agree with the "work performance only" approach. The program does not help the supervisor directly, but helps employees and this, in turn, gives the supervisor a better worker.

L. strongly agrees with constructive coercion–*"You have to give a person a reason to want to change."* However, constructive coercion is not applicable to non-alcohol problems. For example, it cannot be used for an employee with a domestic problem because it may be the spouse's fault.

Referral Process

"If I don't know why they're not doing well, I really can't say, 'Well, I don't think you're doing well, so you had better go ask somebody why I don't think you're doing well.' " An employee assistance counsellor could be of some value if he could deal with any problem and channel the employee to the right resource. This applies only if the employee asks for help. The counsellor may be helpful because *"I keep thinking . . . maybe he's fine and it's me that's crazy."* L. states he would reject a referral by his own boss if he were having home problems but would accept a referral on the basis of poor work performance.

Treatment Effectiveness

L. believes treatment can definitely help resolve behavioral health problems. However, he sees treatment as separate from work and does not believe these two need to be coordinated–*"Work is work, it's not some kind of social program to help an individual."* L. admitted that the counsellor might consider coordination important between the work place and the treatment agency. However, this does not happen at present. L. feels the employer has no right to phone the counsellor because this would breach confidentiality. He would feel uncomfortable as a counsellor phoning the supervisor. The purpose of treatment is to help the individual achieve a positive attitude and it is up to the individual to avail himself of treatment resources, whether they be professional or not; e.g., he has received good advice from an elderly Indian friend.

Interview No. 6, continued

Problem Employee Example

Problem

The problem employee is twelve years older than L. He was initially very nervous, constantly checking to see if he's doing OK. Initially he was a pretty good worker. Subsequently his production was down, he made mistakes and sometimes refused direction. He became belligerent after receiving permanent appointment. He refused to wear required safety equipment and complained that workers in similar jobs were being paid more. L. believes he had problems at home as he tended to perform poorly on Mondays after spending the weekend with his wife.

Intervention

L. put his concerns on the annual rating form and discussed these with the employee. The employee became very angry for a while. L. also used his mistakes to demonstrate to him the need to change. L. notes that *"I can't do a heck of a lot unless he asks."* regarding the home problem. A central issue was L.'s need to establish his own role as boss. He attempted to confront the employee concerning his poor performance. However, the employee said he did not feel good, was too old, and everybody makes mistakes. L. concluded that *"he had emotional problems–probably brought on by stress at home."* L. kept a record of all problems and believes the employee saw this record. This resulted in improved behavior. L. would withhold a raise if there was no improvement. L. notes that the employee's wife had been very ill and has subsequently died. He had not been aware of her illness.

Outcome

The employee is doing quite well now. L. believes treatment would be of help to him but he won't accept treatment because he is not aware that he needs this. L. hopes he will find a good woman to be a companion for him.

When he encounters work performance problems, L. relies on his senior manager as a resource. He feels everyone should be made aware of the program and temporary employees should have access to it. However, the program is very much in the background. However, *"Anything that's gonna help toward a better, more stable employee is good for the company as a whole."*

Interview No. 7

Locksmith. No permanent employees under his supervision. Had supervisory duties before coming to work for the Alberta government. Has been a member of AA for sixteen years.

Need for Program

Regarding problem employees, J. considers their work disruption a minor issue as there is a life involved. *"A life is much more important than getting the job done."* However, the program is also good business. The program benefits the supervisor by rehabilitating the employee. J. has little awareness of the program as a management tool. He estimates that 3–4% of employees are alcoholic and the incidence of other behavioral health problems is slightly higher. The number one problem is attitude.

Method of Motivation

When alcohol or drugs are a problem the supervisor should try to get them into treatment. *"Lots of times you have to be a little harder on the person than you would be otherwise to get them to seek help for their own good–I know in my case if somebody had clamped down on me a little earlier I'd have probably gotten help before I did."* J. notes he would not have the authority to use constructive coercion but would refer to a senior manager for this.

Referral for Treatment

Treatment effectiveness depends on the employee's personal desire for help, whether constructive coercion has been used or not. *"Nobody goes to Henwood because everything is rosy."*

Example of Problem Employee

While working for an employer with no assistance program J. had a problem employee. He was absent for a few days after each payday and frequently came to work hung over. He did good work when he was working.

J. urged him to attend AA on a personal basis but the employee refused.

The employee remained for three months but was dismissed when the work load increased and his sporadic attendance could no longer be tolerated.

Interview No. 8

Aerial Wildlife Survey Section, early thirties, seven years with government–five as supervisor. A. is a union member with supervisory duties but supervision is a minimal part of his job as he has only one employee.

Need for Program

A. does not know of any employee problems in his present work place. He notes that people are interested in their job and work in a good environment. This results in fewer problems. A challenging job contributes to good work performance. In a previous job A. worked on a routine, boring assembly line. This contributed to employee problems.

A. had one employee who separated from his wife. This led to a depression which affected his job at times. A. talked to him about it at times but the employee wanted to work it out himself and has apparently done so.

A. believes the employer should provide an assistance program as a *"people thing"* i.e. a humanitarian approach to give the employee a chance. The program helps the supervisor by restoring the problem employee to good performance. Saving money is not an important purpose.

Role of the Supervisor

The problem employee should be treated by a counsellor instead of by the supervisor because the program protects his confidentiality. It's up to the supervisor to find out what the problem is–if he does not want to tell personal problems to the supervisor he should see a counsellor. A. would go to his own supervisor if the employee refuses help. If he still refuses he should be dismissed.

Constructive coercion should be used as a last resort only. It would work best for an employee with seniority who is motivated to keep his job. Constructive coercion is a good technique but should only be used by senior managers as the on-line supervisor does not have sufficient authority. Alcoholism and other behavioral health problems require the same approach by the supervisor but should be referred for different types of treatment. Motivation is ultimately the employee's personal responsibility.

A. believes the supervisor has good support from senior management. The decision to refer a problem should come from senior management as the supervisor must follow the formal chain of command. The supervisor may initiate the referral but has to be careful to protect himself.

A. admitted he has very little comprehension of the program.

Interview No. 9

Administrative General Yardmaster–looks after operation coordinators and general yardmasters regarding work and holiday schedules, disciplinary action, safety program etc. Involves martialling trains, coding the hump yard, etc.

Need for Program

Most common problems include failure to work, lateness, not doing the job properly, booking sick to avoid work, etc. These are usually attitude problems–not illnesses. Behavioral health problems are a minor cause of work performance problems. The supervisor is not in a good position to identify problem employees. He must rely on the work record, a chance encounter with a misbehaving employee or a report from the union. The employee may answer to four different supervisors at a given time. Front line supervisors are union members and may cover up for a problem employee. For example, the yardmaster is a union member and may be partial to his friends. The union role conflicts with the program as the union tries to defend the employee regardless of the merits of the case. This makes it harder to confront the employee with his responsibilities. Consequently problems may drag on for two or three years before the employee is fired.

The employer has a moral obligation to the employee to provide help if needed. The supervisor benefits by having a problem employee rehabilitated. (Union membership is optional for senior managers. P. has opted to withdraw from the union.)

Method of Motivation

The CNR uses the Brown system of discipline but this has no value to most employees. The only way to fire someone is to assess demerit marks until the employee reaches a total of 60–or to find him guilty of gross misconduct or intoxication on the job. P. believes they should be able to bring a problem to a head quicker and fire employees who do not want to improve. The supervisor often relies on hearsay information regarding employee problems or checks on an employee who is suspected of being intoxicated. In the disciplinary interview the employee is asked if he has a problem. If he admits an alcohol problem he is referred to a counsellor. However, the employee usually denies having a problem.

Facing an employee with his responsibilities helps get him into treatment. Often an employee is fired for violating Rule G. He then gets treatment on his own and can be rehired after a period of sobriety. P. noted that he cannot recall a single individual who accepted treatment before being fired. However, some alcoholic employees seek help on their own from lay counsellors in the company.

Referral Process

P. sees the program as a resource to the supervisor in that it tells him where to refer an individual. The supervisor may check with the company counsellor to see how the employee is doing. The medical department is a prime resource, e.g., if the problem employee denies having an alcohol problem the supervisor may refer him to the doctor. If the doctor finds proof of alcoholism the supervisor can use this to persuade the employee to see a counsellor. The counsellor decides if he should go into the program. The doctor helps convince those you can't convince yourself. However, the employee can reject the referral to the doctor.

Treatment Effectiveness

The effectiveness of treatment does not depend on coordination with the work place. Rather, it depends on the employee's response to treatment. The supervisor needs feedback from the counsellor as to when the employee will return to work. The supervisor may also obtain feedback concerning the employee's progress and attendance in treatment and assurance that he is trying to overcome the problem.

Example of Problem Employee

A yard foreman tried to leave work early and booked off sick when asked to complete his shift. He was assessed ten demerit marks as he had previously come to work late and had been reprimanded. He had previously refused a reassignment of duties and booked off sick. He was a fairly new employee and had listened to other employees who had suggested he was free to act in this way. This resulted in a cocky attitude. This employee simply had to be taken down a peg. Since receiving the demerit marks the problem has been corrected and he has been promoted to the position of yardmaster. P. notes that this was a typical case.

P. also noted that he knows of an employee who is apparently a late-stage alcoholic. However, the employee does a good job and management cannot get him into the program.

Interview No. 10

Salary Clerk Supervisor, union member with supervisory duties, has been with the government for three years.

Need for Program

Most problems are due to a lack of ability or training or they don't like the work. Health problems affect fewer people but the program is worth while for those who do have problems. (L. had noted that the number of employees with behavioral health problems is not significant–however she estimated that 10% of all employees have such problems.)

The employer has a moral obligation to provide help to problem employees. This also saves money but this is not the primary reason for the program. Senior management would support the supervisor in utilizing the program (although she had disagreed on the questionnaire).

Motivation

If a problem is suspected the supervisor should try to handle it, i.e., ask them to explain what it is. L. notes that they may not feel comfortable but the employee would have to try to explain the reason for poor performance. She notes that we all have to learn to separate work from home. However, if the problem is so bad that they can't, then they do need help. Then it is up to the employee to attempt to get help. If she does not want to, the supervisor would have to take action. L. does not know if you can force people to get help. However, the employee would have to talk to somebody or be dismissed. L. notes that some would seek help on their own but many won't.

The supervisor is responsible to see that work gets done. If necessary, she must force the employee to accept a referral. (Does not like the word "force".) She notes that facing the employee with their responsibility increases the chance that they will accept treatment.

Constructive coercion is more effective with alcoholics but is not a proper part of the supervisor's job due to her lack of authority. L. does not want the authority to implement constructive coercion on her own as this should be the role of senior management who have more experience. The supervisor should be prepared to use constructive coercion, with adequate backing, although it may be difficult at the time.

Referral Process

The decision to refer is not up to the supervisor. She would also not recommend any special treatment agency but would tell the employee what is open to her. L. considers the Diagnostic and Referral Unit as a source of help somewhat similar to Family Services. She did not know about the Unit's referral function to other treatment agencies. She believes all employees should know about the Unit and its services. L. stresses that she would recommend the employee see a counsellor in addition to their family doctor as medical practitioners do not provide comprehensive counselling services.

The supervisor can get referral information from the senior manager or personnel officer. *"You don't do anything on your own without going to the next step (in the organizational hierarchy)."* L. feels she has adequate consultation through the Diagnostic and Referral Unit but would not know whom to contact if the Unit was not available. Regarding the diagnostic and referral service she stated *"I think all big agencies should have a service like that."*

Interview No. 10, continued

Treatment Effectiveness

Coordination between work and treatment is important but does not contribute much to the effectiveness of treatment. Personal information should not be exchanged. She believes coerced employees do benefit from treatment and some would come to appreciate the coercion at a later date.

L. considers the program worth while but does not know if it is effective. She notes it is useful to know the program is there and that there is backing for the supervisor and the employee. The greatest value of the program is that it helps people to recognize problems. Its greatest weakness is the lack of information available regarding the program.

Example of Problem Employee

A new employee was slow catching on to her job as she had never worked before. She was making mistakes, not remembering things, not looking up information, not asking questions of her supervisor because she was afraid to appear stupid. She lacked self confidence and the age difference caused difficulties in relating to her supervisor. L. did not suspect any underlying problems but considered the job *"a bit too difficult for her."*

L. pointed out her mistakes and consistently asked her to redo unsatisfactory work. The employee overcame her lack of confidence on her own.

After approximately six months the employee *"worked out OK."* However, L. notes she would not have hired this employee if she had been involved in this decision.

Interview No. 11

Union member with supervisory duties, caretaking, fifty to sixty years of age, supervises seventeen men.

Need for Program (Role of Supervisor)

E. states that his primary loyalty is to management although he has some ambivalence. Sometimes he feels that senior management *"couldn't care less"* about the employee, whereas the supervisor has a personal concern. The supervisor can deal best with work performance problems on the work site, i.e., by pointing out what is wrong and demonstrating how to do the job properly.

A typical problem is the employee's attitude that *"for the amount of money I'm earning, I'm doing enough work."* E. notes that *"I'm no slave driver–I was driven at one time."* (This feeling was expressed by a number of supervisors.) E. believes that government is very different from private industry in this regard. It takes a very concerned employer to refer an employee. E. notes that mentally ill people are not employed, therefore *"we don't work with those things."*

Most supervisors cover up performance problems and tell senior management that everything is OK. E. does not believe in that. However, *"I would cover up for a while."* He points out that this is risky for the supervisor.

Method of Motivation

Employees often talk to their boss at work about domestic problems and expect this role of the supervisor. Often the problem is something at home which shows up at work.

An employee with poor work performance can be given a poor annual rating. The supervisor could dock him for missed time but this is complicated and not effective. E. feels he has not received enough support from senior management with regard to discipline. When a problem employee is referred to senior management he receives a verbal reprimand and/or a letter of warning. This is considered a very strong form of action and is understood to be a threat of dismissal. The letter advises the employee to *"smarten up"* and is usually effective.

Senior management usually says *"that's your baby,"* when the supervisor refers a problem employee. However, this is not so. *"When it comes to behavioral problems with an employee–that's beyond my capacity as a supervisor."* E. believes in constructive coercion but as a union member feels he should abstain from threatening dismissal. Also, this is not supported in this organization. (It worked well in private industry.) Also, E. states he has insufficient authority to utilize constructive coercion. This is up to the counsellor and E. would apply some pressure if a counsellor were available.

Referral Process

E. believes a professional counsellor should be available as the supervisor is not trained to deal with behavioral health problems on the job, e.g., the employees have limited education and there are some language barriers. Therefore, the supervisor has a hard time finding out what the problem is. When asked about the availability of a counsellor, E. stated *"I think there is something."* However, he would not feel comfortable phoning AADAC as the employee may not be alcoholic. Therefore, he would use only discipline.

E. believes an employee cannot be dismissed for behavioral disease but must be offered treatment first. Management may expect the supervisor to offer treatment but this should be the role of the counsellor. However, a counsellor would be involved *"only if it's a real tough case"*–as a last resort. E. believes the supervisor and counsellor should work closely together as the supervisor has valuable input for the counsellor. (This has not happened but should be the procedure.) Decisions concerning treatment are the responsibility of the counsellor. At the suggestion that the counsellor might coordinate between the work place and the treatment agency, E. stated *"that would be great."*

Treatment Effectiveness

"They say 'alcoholics can't be helped by anyone, they must do it on their own.'–I don't believe that." E. feels he does not receive adequate feedback from treatment agencies. He notes that constructive coercion does not reduce the success of treatment but may enhance it.

Example of Problem Employee

The employee was a henpecked husband who couldn't open his mouth at home. Consequently, he talked to everybody too much at work. E. often received complaints about the employee's sloppy work. He was often absent as well. (E. notes that no doctor's certificate is needed under three days.)

E. provided reassurance to the employee that his problems would clear up. He also advised the employee to compromise with his wife. The employee became angry at this and accused E. of being against him as well. Consequently, E. urged him to get on with his work, suggesting that he would feel better if he kept busy. He also advised the employee to separate home problems from work. Eventually E. referred the employee to senior management because of ongoing poor performance. The senior manager confronted the employee with a choice between improving his performance or resigning. The employee resigned immediately and the problem was *"solved."*

Interview No. 12

D. is a Plant Maintenance Department Manager reporting to the Plant Manager. He is in his thirties and is a manager who supervises the front line supervisots.

Example of Problem Employee

Nature of Problem

The supervisor first noticed the problem six or eight months ago. (D. has supervised this employee for the past year.) He has heard stories about this employee's problems from past years. The employee was absent due to a drinking problem. However, this was discovered through rumor from other employees and can therefore not be used in confronting the employee. The employee became *"jumpy"* and refused to take direction from his foreman.

The employee was in an apprenticeship program for which he qualified on the basis of seniority. (Four-year trades program at NAIT.) The employee was very apprehensive concerning his math course and missed a number of classes. The union had provided a tutor and he passed his final exam in February. He now seems relieved and less tense. However, D. feels his problem may recur in other stressful situations.

Several months ago the employee phoned his supervisor on a Sunday night to state that he had admitted himself to the Recovery Center at AADAC. He returned to work three days later and seemed to be OK for several weeks. A second incident occurred in a dispute regarding overtime. The employee became very upset, shaking and crying. The supervisor suggested he take some sick leave. He returned on the third day.

Intervention

D. notes that he is not overly concerned about the problem as yet. However, he is concerned that the problem will probably get worse. He has discussed this employee with the company nurse and the personnel director. At their suggestion he offered the employee a referral to the nurse. However, this was refused. D. notes he has no documentation regarding the problem incidents as management has become lax in this regard. If the employee is willing to see the nurse she will recommend a treatment program and he will receive medical coverage during treatment.

D. notes that this employee's problem has not yet cost the company any money. If the problem begins to affect his work, D. will tell him he has to get help. If her refuses this, a constructive coercion approach will be used. However, D. states *"It will have to affect his work very much more than it has done before I would take any action."* He notes that he must be very cautious and that it may not be possible to dismiss the employee due to strained union-management relations. He notes *"I won't take any action unless something happens,"* i.e., his performance adversely affects the operation of the plant. However, D. will not watch him closely but will rely on regular feedback from the foremen.

Referral for Treatment

D. feels it is very difficult to force treatment on somebody, especially when the problem has not affected his job and dismissal is not justified. He acknowledges that this is a very difficult spot for the supervisor, *"We're all amateurs in handling people with this kind of problem."* . . . *"You know the guy's got a problem but your hands are tied–you can't do anything about it."* D. states that he *"would like to be able to suggest that he needs treatment and have him agree with me . . . I don't think it works out that way . . . I don't think suggestion is good enough."* D. feels it would be presumptuous of him to get involved in the employee's per-

Interview No. 12, continued

sonal problems. (He believes the employee has an underlying insecurity problem and may have home problems as well.)

Regarding professional treatment, D. states *"I don't know how much they do to help a problem."* The biggest part is that the guy has decided to help himself. Counselling may help a bit. D. sees the nurse as his primary resource but does not know if she has any special training. He feels more professional consultation is needed. A nurse with experience in counselling would be a good resource. (She would provide contact with AADAC.)

D. feels ambivalent about his own role as a counsellor. He does not mind the role but is not sure how to help. He believes he should be concerned only with the employee's work habits as it is presumptuous to take on the role of a volunteer counsellor. He also does not know the employee well enough to recommend treatment without having a specific problem incident to deal with. He notes *"I don't have any way to motivate the employee that I'm willing to use right now."* The supervisor's role in recommending treatment is that of a friend.

Program Rationale

The company has a responsibility to provide help as a good corporate citizen. Less than five percent of employees have alcohol problems. Most problems are due to insecurity and personality problems. The supervisor should provide counselling and support. The program increases the supervisor's willingness to get involved. However, he is not responsible for the problem and is not obligated to take action to help the employee.

The program needs a better way of motivating the employee without adding to his stress or threatening him with dismissal. Constructive coercion may turn the guy right off and is beyond the supervisor's ability. Acceptance of treatment may help or hurt the employee's opportunity for promotion; i.e., it may confirm for the manager that this is a problem employee, or may gain his respect for dealing responsibly with the problem.

Interview No. 13

Assistant to Superintendent of Plant. Supervises four junior supervisors. Is in his thirties with eight years' experience as a supervisor. (The plant has 1–2% turnover per year.)

Need for Program

A new employee is quickly socialized by union members and learns to play one against the other, i.e., union against management. The company does not have the control needed to straighten him out. Workers bait the supervisors and try to create conflict. The plant is controlled by a subculture of employees–not by management. Therefore, the supervisor's attempts to control the workers results in deliberate inefficiency which is used as retaliation. The problem employee is a hero in the lunch room. Union leaders reinforce poor behavior and blame the work environment as a means for gaining concessions from management. Consequently, the supervisors have sided with the employees, i.e., they are deliberately lax in exercising discipline because this improves production.

Employees use sick time to go fishing. Most work performance problems are due to the prevailing management style and to the low average age of the employees. The company pays its employees too well. Therefore, overqualified people work there and feel bored. They perceive themselves as failures and use their intelligence to cause problems.

Employee assistance programming and performance problems are two separate issues. Performance problems require control whereas behavioral health problems require an offer of help. Employee assistance programming is also good business and the union wants a program included in the contract. The union does not want management to solve problems alone; e.g., alcoholism. They want involvement in the program.

Supervisors have to identify employees as alcoholic before taking action. Management supports the supervisor in making a voluntary referral for treatment, but not in confronting performance problems.

Method of Motivation

The company treats employees very well; e.g., never refuse a request for a day off and don't ask questions about the legitimacy of sick leave, etc. The company has just lived with the above problem for the past two or three years. However, it is planning to tighten its discipline after the strike is settled. It is expected that the company will have to cope with decreased production for a while.

The employee assistance program is good and necessary under ideal conditions. However, the company can only dismiss employees who have no good union connections. However, the answer to employee problems is not to fire the employee. At present a problem employee can simply back off for one or two months when he is under pressure from management. G. feels that most would reject an offer of career counselling even though they may be unsuited to this type of work.

The present disciplinary process involves (1) a verbal warning; (2) a written warning; (3) official reprimand or discipline. At present management's right to utilize these steps is consistently challenged by the union. However, the company plans to implement each step successively and at least gain the right to utilize steps (1) and (2). The increase in management control would turn a lot of problems around. (The alcoholism program is not concerned with a major part of the problem.) Presently, management does not confront employees often because of union pressure. Instead, they hope for a voluntary request for help.

In the case of an employee problem, the first approach should be on the basis of talking and a friendly offer of help. Confrontation is a last resort and the supervisor would have to capitalize on a very significant incident. Most employees in the program get involved on a confidential, informal basis. The supervisor can also try to get cooperation from the employee through the union steward.

Interview No. 13, continued

In response to a description of the provincial program G. stated that this approach would work if all of management utilized it. He would favor this approach because it is fair and honest. At present employee problems usually lead to compromise between union and management. Management cannot keep track of the outcome of specific interventions regarding problem employees. The company is at fault for having very lax rules.

Referral for Treatment

The supervisor's prime resource is the director of personnel and the plant nurse. The major employee problems are due to social change and the company's management style; e.g., G. considers his son less responsible than he was at that age. His son *"works the system"* on his paper route. The company provides too many benefits to its employees and the union leaders are on an ego trip. As a result, the supervisors are almost washed out. They take the easiest out by denying that problems exist.

Example of Problem Employee

Problem Situation

A five- or six-year employee started as a reasonably good worker. He has a university degree but is working as an ordinary production worker. He got involved in sports with other employees. In his second year his absenteeism rate increased, his performance decreased and he began to resist supervision; e.g., insisted on reading a book on the job. This affects other workers because it sets a bad example. These problems tend to develop gradually starting with the second year of employement.

Intervention

The supervisor was advised to *"look the other way."*

Outcome

The problem is ongoing.

Second Example

An alcoholic employee with additional behavioral problems was fired for stealing beer from the plant. The union got him into a treatment program and accused the company of firing him for being alcoholic. As a result of the grievance procedure the employee was reinstated. It would appear that the program is seen as a disciplinary tool.

The supervisor did not connect the employee's drinking problem with his behavioral problems on the job. The employee had a history of excessive absenteeism. The supervisor pushed him to admit to the personnel director that he had home problems as well. (G. implies that a recognition of behavioral problems as treatable illnesses may be used against the company.)

Interview No. 14

Vice President and General Manager of Labatt's Alberta, in his forties with ten years' supervisory experience, nine years with present company.

Example of Problem Employee

Problem Situation

Senior manager who was good at planning but poor at implementation. Previously worked in a situation where the union cooperated with management. In present job his area's efficiency rating is 78–80% as compared with 92% elsewhere. He has lots of talent and ability and J. does not know why he is not more effective. *"It baffles me how counselling will overcome this problem."*

Intervention

Management plans were documented and agreed on. The employee never admitted he needed help and J. states he does not know what kind of counselling was needed for him. He notes that he could have involved human resources consultants but did not do so. J. states he did not see the work performance problems as indicative of a behavioral health problem. *"No amount of counselling would change that guy."* He just did not fit the situation. The employee disagrees with J.'s assessment of his performance but admits that he was staying on the job because he was afraid of making a change.

Outcome

The employee was asked to resign. J. notes he is very sensitive concerning the possibility of repercussions due to the resignation; e.g., it could be interpreted that the company has scapegoated this manager. He is also very costly to replace. J. notes that the manager was offered a transfer but refused because it would involve a relocation.

Need for Program

The company does not have adequate personnel consutation. Also, J. does not know where to get clinical consultation or in which situations it should be used. He notes that he could name half a dozen from the plant who have a bad attitude. The great bulk of the company's known problems are in the plant. They are due to the work situation, i.e., environment, management style and organizational structure, as well as the terms of the collective agreement. Most of the problem employees have no personal problems. Their behavior results from the terms of the contract and the social situation in the plant. Consequently, a long term solution is needed. J. believes too many concessions were made in the collective bargaining process and it is now almost impossible to manage the company. He strongly agreed that the total organization has a behavioral health problem.

The employee assistance program is a major issue in the negotiations. J. does not want it in the collective agreement because it is too sensitive an issue. J. notes that he attended an Edmonton-wide union-management committee on EAP. His expectations from the union are simply that they refrain from creating roadblocks to the implementation of a program. *"The union are very suspicious about management's motives. They see an employee assistance program as just another way of firing one of their brothers."* J. feels management is less emotional on such issues than is the union. *"The company doesn't hire the employees–the union does (through the hiring hall). Consequently, the employees feel they owe their job to the union."*

The union wants credit for the alcoholism program. J. notes that there is a similar problem in the safety program; i.e. the union's primary interest is in obtaining large prizes from the company for employees who maintain good safety records.

Method of Motivation

The company's program is essentially alcohol-oriented. J. cautioned that I should not overemphasize its relevance for other problems. J. feels that alcoholic employees cannot be motivated until the problem is very extreme. Meanwhile, the union sacrifices the welfare of its own members for political ends. J. does not want the program in the contract because it should not be subject to arbitration; i.e. on one occasion the company was ordered to take the problem employee back after he had been fired for theft. This employee admitted theft but pleaded that he was under the influence of alcohol and therefore not responsible for his action. The implication is that problem employees are exempt from normal disciplinary action. Accordingly, the program provides a protective cover for problem employees.

Referral Process

The medical director of the company examined a number of problem employees but none were diagnosed as alcoholic. One individual resigned as a result and this solved an organizational problem. The employee had been involved in horseplay and absenteeism. However, this intervention did not help the problem employee.

Treatment Effectiveness

J. is aware of one alcoholic who received treatment and has improved in his attitude and attendance. He was previously very volatile.

Interview No. 15

First Line Supervisor in his forties with fifteen years' experience as a supervisor. He reports to the Brewmaster in the Brewing Department.

Need for Program

Fifteen out of twenty-four employees had performance problems. J. does not like to lean on people and notes that the company treats them *"super."* However, they do not show corresponding respect to the supervisor or the company. J. believes the problem is due to the union atmosphere where there is no sense of responsibility. For example, an employee may ask for the following day off. The supervisor invariably tries to grant the request. However, if he refuses the employee threatens to book off sick–knowing he can get away with this. Thus, if the supervisor refuses his request the employee is still away and has not used up any holiday time. In addition, the supervisor cannot make any plans to replace him until he fails to show up the following morning. J. considers such strategies worse than guerrilla warfare.

He feels most performance problems are due to union power rather than to behavioral health problems. At some stages there's the odd guy with health problems, e.g. one employee is overweight. However, he did not make use of the fitness program.

J. feels that employees lack respect for management and would appreciate stricter discipline. He considers their poor attitude as a general behavioral health problem; e.g. employees threatening sabotage by stating *"If you discipline him some beer will disappear down the sewer."* The supervisor's conflict lies in trying to maintain respect when he cannot deal with the problem head on.

The union does not like its members to work too much; e.g. they threatened to reject a man from union membership because he was working too hard.

J. believes the assistance program is for the benefit of employees. The union also benefits from having its members rehabilitated. J. states that he wants to help the employee who has a problem but does not want to know about personal problems if they are not affecting work. J. is prepared to help and counsel the employee who asks for help; e.g. he recommended that an employee obtain a loan from the Bank of B.C. in order to consolidate his debts. J. believes that the underlying problem is that *"We've got no standards."*

Method of Motivation

The ideal situation would include the following disciplinary steps:

1. Talk informally about the problem and offer assistance. Refer to Personnel, the Nurse or a Senior Manager if the employee is willing to accept help.
2. Document further problems and interview with the shop steward.
3. Give the employee a written warning and hope he gets help.
4. Dismiss the employee if he does not improve.

At present, if the supervisor tells an employee that he is not satisfied with his work, the employee denies that there is a performance problem and demands to see his shop steward. The steward invariably supports the employee, i.e., minimizes the problem and looks for some sort of benefit as a trade-off.

Interview No. 15, continued

On one occasion J. tried to counsel an employee who was also a personal friend. He used strict discipline and gave the employee a written warning. The union dissolved the safety committee in retaliation because J. refused to retract the disciplinary letter. Senior management urged him to retract the letter as well.

J. feels the supervisor should try to convince an employee to see a psychologist and to help him understand that no stigma is attached. He believes if the union and management did what is right, behavioral problems would disappear. At present, the organization of the work place causes personality problems. Because the supervisor cannot put pressure on the employee he can only offer help on an informal basis. If the employee refuses, the supervisor can refer him to senior management. J. believes that an employee who fails to overcome his problem after having attempted to do so should be considered for transfer to another area. The employee is not responsible to get help on his own, but needs support, advice and direction from the supervisor. J. feels he has *"got to take care of the guy."*

Referral Process

The supervisor offers help but the decision to accept help is up to the employee. The supervisor may be wrong in his diagnosis of the problem or his technique in dealing with it. Further action is up to senior management. If senior management agrees, the supervisor may use discipline or recommend a transfer.

Example of Problem Employee

This employee started with the company ten years ago and J. has supervised him for seven or eight years. They were initially friends before J. became a supervisor. This was a good worker initially, however, his work performance deteriorated when he was paired with the union president on a job assignment. He began coming in late, leaving early, taking extra coffee breaks and refusing direction. J. and the employee continue to be friends off the job but there is constant conflict at work.

The problem is ongoing and J. feels the employee is deteriorating as an individual.

J. notes that the program requires cooperation between management and union. There should be a positive approach for the benefit of the employee.

Interview No. 16

Electrical Maintenance and Construction, government center area. D. is in his fifties with twenty-six years in government service. He is a union member but feels he represents the employer and sees no advantage to being formally in management.

Need for Program

D. is very satisfied with his crew. They are older, established men who have been with the government for approximately fifteen years. He also has several good young apprentices. Concerning the problem employee mentioned below D. states *"I think everybody should be helped in that state."* From the employer's point of view the program is to save money. From the supervisor's point of view its purpose is to help the employee. D. feels the employer should have some commitment to help the employees. The supervisor benefits from the rehabilitation of the employee. D. does not consider that the program provides an improved management strategy.

Most work performance problems are due to alcohol, i.e. approximately 10% of all employees. Fifteen to twenty percent of employees are below work performance standard. D. does not consider this a significant percentage. He feels many employees get in a rut and need a change. Therefore, they perform poorly. *"The more interesting the work the better the employee will perform."* Most alcoholics do not acknowledge their problem.

Method of Motivation

D. states he does not really know how to motivate problem employees to accept help. *"That's where I was stuck."* He doesn't really know if it is his responsibility to try to help a problem employee. However, he would go to a senior manager sooner with a problem now that there is a program because it is easier to get the employee into treatment. D. feels you have to convince them that they do have a problem. *"How do you do that?"* This is the main problem. D. feels constructive coercion should help if the employee has rejected other attempts to motivate him. However, he would not like to have to use constructive coercion as *"it could hurt me."* However, he feels it would help the employee. He feels most problem employees will accept help voluntarily. D. believes that failure to overcome poor work performance should not lead to dismissal until help has been offered. The supervisor should be concerned with the employee personally. The offer of treatment should be given both as a supervisor and as a friend. D. feels he should not get involved in employees' personal problems. He also feels that constructive coercion is not solely his job but should involve senior management.

Referral Process

D. states he would refer sooner if counselling services were available in the company. The supervisor would request consultation from the counsellor and would refer the employee directly to the senior manager with a recommendation that assistance be provided.

Treatment Effectiveness

Treatment is usually effective. Coordination is important so that the employee can receive treatment while remaining at work. D. feels the program is useful and has no changes to suggest.

Interview No. 16, continued

Example of Problem Employee

Problem Situation

An employee with an alcohol problem who had been with the government for ten years. (This was quite a few years ago.) D. was his foreman in 1969 and the employee was a problem then. The employee was not there most of the time and lax on the job. He was referred to a senior manager and effectively supervised by the senior manager thereafter (still technically working for D.) The employee had home problems and was an alcoholic. This was discovered by hearsay, smelling liquor on his breath and through complaints lodged by his assistant.

Intervention

The employee was fired in 1974. The union (CSA) became involved and referred him for alcoholism treatment together with his wife. He was subsequently rehired and did very well and was a changed man. Initially, he had been transferred to an area away from the other men and was watched closely. However, he did not improve but this move was helpful to the rest of the crew. D. feels he may have felt neglected. D. does not know how the union got involved. However, the union launched a grievance against the employee's dismissal and won his reinstatement.

D. states he did not talk to the employee about his problem as the employee was shy about it. When confronted with his poor work performance he shrugged this off. D. received no advice from his own senior manager who was also an alcoholic and did not consider this a problem.

Outcome

The employee attended AA and is now *"working out 100%."*

D. notes that he has not thought through the program very thoroughly and felt somewhat unprepared to respond to the questionnaire.

Interview No. 17

R. is in his twenties and has three years' experience as a supervisor. He was recently promoted to Laborer 3 in Horticulture with the Parks Department. He has one full-time and several part-time employees. He reports to a foreman and is a union member with supervisory duties.

R. feels it would be better to be out of the union because it defeats the purpose of being a foreman when he is in the union and on the employees' side. R. states that his loyalty is with the employer but he looks out for the men too. As a non-union manager *"I would try to get the most work I can out of the men."* e.g., no extra five minutes for coffee–but this would result in less cooperation from the men as well.

Need for Program

No one relies on the union–I tell them what to do and they do it. The union does not have much to do with the work place.

A behavioral health problem is a guy who does not want to work–a slack guy. Most problems consist of a poor attitude. Alcoholism is the root cause.

Method of Motivation

Concerning a problem employee, R. states, *"If I was a better friend to him I could tell him he needs help."* However, the employee would get angry. R. considers the offer of treatment as being far beyond the work relationship. He would have to catch the employee drunk in order to confront him. (R. showed little recognition of work performance as a basis for referral for treatment. He notes that he would not confront an employee *"as long as things were going smooth."*)

R. considers the program as a resource in that it provides an alternative to dismissal. However, it does not provide a means of motivation. He feels a pamphlet should be provided to employees, encouraging them to seek help. R. states that he is very reluctant to confront an employee. Rather, the program consists of a voluntary offer of help and is only for those who want help. Constructive coercion works in that it gets a guy to treatment but it does not assure that he will want (or utilize) the help offered.

Referral Process

R. would go to a senior manager for advice regarding treatment resources and then involve a counsellor. The medical department of the company would be the prime resource because of his commitment to the employee.

Example of Problem Employee

Situation

A fifty-seven-year-old employee who was with the City for sixteen years was found drunk at work by a senior manager. The employee had often come in with a hangover and word of mouth reports about him from the past indicated that he was not reliable, often came in late on weekends and asked others to cover for him. He has had a problem due to his wife's illness for the past five years. (She died one month ago.) On one occasion someone phoned in a complaint stating that the employee had stolen lumber from work. This was subsequently verified.

Interview No. 17, continued

R. feels the employee is doing better since his wife's death. However the wife's illness was not the main problem. The employee was *"just getting slacker over the years."* He phones in sick a lot and has interesting excuses; e.g. underwent surgery for piles one day and showed up for work in excellent health two days later. R. notes that the employee has a long history of poor performance but notes that he gets along well with the employee and he is a good worker–he is still missing time due to alcohol.

Intervention

Upon finding the employee drunk, the manager threatened him with dismissal and sent him home for the day. There was no offer of treatment. When he was caught stealing lumber he was *"labelled as a thief"* and stripped of his keys. R. notes that management had to act on the complaint because it was phoned in by a citizen.

R. notes that the employee is still friendly with himself but not with the senior manager who disciplined him. R. plans to carry on as he is at present but will transfer the employee to the senior manager's area if the problem cannot be coped with. He notes that he has received no support from senior management for further confrontation of the problem. He acknowledges that he is conspiring with a senior manager to hide the problem, i.e. put -------- where he won't disrupt anything. The City is carrying the employee until retirement as a form of social assistance. (He's been around too long–we can't fire him. He's a good man . . . during the summer . . . when he's there.) R. feels they can live with the problem all right, although other crew members are upset at having to carry the problem employee. R. feels he may supervise the employee more closely and states he will *"straighten him out"* by stepping on his toes. R. notes that he thought the problem was funny last year when he was simply a co-worker instead of the employee's supervisor.

Referral for Treatment

When asked about the possibility of confronting the employee with the need for treatment, R. burst out *"I couldn't say that to old ——————".*

Interview No. 18

J. has just been promoted to a position as Parks Foreman responsible for construction and maintenance of parks facilities. He is in his thirties.

Example of Problem Employee

J. noted on his questionnaire that he had been married to a woman with alcohol and drug problems. He was asked to elaborate on his perspective of the problem as a husband as well as a supervisor who might employ individuals with similar problems.

J.'s wife was addicted to codeine, valium, alcohol, etc. He describes her as a loner who was dependent on her parents and may have had a *"weak character."* He notes that *"we got her to get a job."* i.e. in an effort to help her overcome her problems. She worked for Woodwards for a year in 1968 and for several months in 1975. However, she developed headaches and required painkillers. He notes that at one point she was taking six or seven hundred C2's per month. She missed work often and did not phone in. However, she had a very understanding manager. She was taking *"quite a few pills"* at the time. J. does not know if her supervisor knew about the drug problem but feels she must have done well at work because she got quite a few raises and a promotion. J. notes that *"we had her in the hospital"* i.e. under the care of a psychiatrist. However, *"until they want to accept (help) there's nothing anybody can do."* Approximately six months ago she turned to beer and could drink anyone under the table. She is currently in hospital with a leg infection and had a blood clot in her lungs. J. has been divorced a little over a year.

J. feels in the earlier stages an employee assistance program might have helped his wife. He does not believe the manager's patience was helpful to her. He feels the manager should have reviewed her record and confronted her with the possibility that she had a problem. He notes that *"You couldn't convince her she had a problem"* but feels she would have accepted a referral if confronted. He notes that her GP cut off her supply of prescriptions and referred her to a psychiatrist as she had been obtaining medications from two or three doctors. At times J. would come home from work and find his wife passed out on the floor and the three-year-old daughter unsupervised. J. states he would have been happy to see her under constructive coercion as this indicates that someone cares. He feels the supervisor was negligent because he did not find out the reason for her absenteeism. Also, the confrontation by the supervisor might have mobilized the family to act as a resource in motivating her to accept treatment.

J. states that in dealing with a problem employee he would

(1) find out the reason for the poor work performance;

(2) ask for a medical report, i.e. the doctor would have to explain the absenteeism;

(3) require that the employee follow through with treatment; e.g., just as an epileptic could be required to take medications in order to control seizures.

J. feels the employee is negligent when he refuses help and the supervisor is justified in utilizing a constructive coercion approach. J. would refer the problem to a senior manager or/and the Personnel Department as the decision to insist on treatment should not be taken by any one person. (Can't play God.) The outcome of this process depends on the individual. Each person has to be handled differently.

Interview No. 18, continued

Need for Program

The purpose of the program is to assist the employee and save money for the employer. These are compatible goals. J.'s personal reason for utilizing the program is that *"I like to help people–don't ask me why–I've been kicked in the face so many times."* J. feels the supervisor benefits by gaining a good employee if treatment is accepted. He notes that *"life is precious"* and he would help an employee even if he would be better off to dismiss him. J. would hope that most supervisors would put the person first, but does not think this is the case. He feels often the problem employee is just not utilized properly. For example, an employee who was not fitting into another work crew was being considered for dismissal. However, J. volunteered to supervise him because he was an independent but hard worker. Through proper management, this individual has become a very good employee.

Regarding his wife, J. cannot see the job as a cause of the problem although he feels it may have contributed. He believes problems may just become more visible on a job. He does not believe that alcoholism is a frequent problem. However, *"If you can help one person the program has paid for itself."* This cannot be measured in dollars.

Method of Motivation

The senior manager is the primary resource. J. believes that individual supervisors tend to relate to problem employees as individual, idiosyncratic cases and fail to recognize the general picture. He would hope that the senior manager would have far greater contacts than the supervisor and that he would have a positive attitude rather than a disciplinary orientation. The supervisor is simply the first cog in the wheel. Constructive coercion is a good technique. Non-alcohol problems are easier to motivate to get treatment.

Referral Process

J. feels consultation concerning treatment resources is readily available; e.g. through the distress line. However professional consultation would be very helpful.

Treatment Effectiveness

J. feels that coordination between the treatment agency and work place is important. He notes that all of the options in Section C, Question 10 of the questionnaire are important. The main problem with the program is the lack of awareness of it among all employees.

Interview No. 19

Senior Foreman 4 in charge of Maintenance and Construction for a parks district. Now acting as district head. J.is in his fifties and has been a supervisor for 14 years.

Example of Problem Employee

Situation

An employee who had been with the City for a number of years appeared to have a slight problem. J. noticed some behavioral changes but could not prove the employee was drinking although he knew the man was drinking more and more. On one occasion he was reprimanded for giving out information concerning future plans for park development to an interested citizen.

A critical incident occurred when the employee came to work late in an intoxicated condition. He acted foolishly in front of the crew and had lost important papers which were later located in his car which had been abandoned after an accident. J. states he does not know how long the problem had existed and does not know if the employee had home problems.

Intervention

Although he had no proof of a drinking problem initially, J. advised the employee to speak up if he needed help. He noted that he was not accusing the employee of having a drinking problem but was concerned because *"I don't want to see you end up in the gutter."* The employee did not respond favorably to this offer of help. However, after the above incident J. helped the employee locate his car and retrieved the papers which had been left unguarded. The employee was suspended for three days for being intoxicated on the job and not taking care of City property, i.e., the papers. An appointment was made for him with the health nurse and he agreed to cooperate. J. notes that he did not threaten dismissal but the employee knew that his job was on the line.

Outcome

J. did not learn the exact nature of the employee's treatment. However, the employee attended the health nurse's office for two or three hours every week. The nurse reported to management on his attendance. J. states that *"As far as I know he's doing good."* The employee was subsequently transferred to another district.

Second Example

A previously sociable employee became a loner. After two or three weeks J. asked him if he had a problem. He admitted to having financial problems when J. made it clear that he was offering help. J. then referred him to a debtors' assistance program and the problem was resolved.

Need for Program

Alcoholism is a major cause of poor work performance and results in absenteeism, morning hangovers, etc. J. notes that he can tell by the voice when the employee phones in sick whether he is drinking or not. J. sees the program as a moral obligation by the employer. However it also improves efficiency and is good business practice. If the employee refuses help the program can provide no further assistance. J. notes that some problems such as depression affect work performance but are hard to demonstrate. He feels the supervisor should talk to the employee on a personal basis as a preventive measure before the job is affected. J. appears to see work performance problems as representing a direct route to skid row.

Method of Motivation

The assistance program works better for permanent employees. The supervisor is responsible to help employees–on his own time if necessary. If the employee refuses help, repeated incidents would result in suspensions until performance is down to zero. J. states the supervisor would offer help even if no program existed because *"I owe it to him."* He states that 90% of problem employees can be convinced to accept help if they are advised of the advantages to themselves of doing so. J. emphasizes that the supervisor should confront the employee with responsibility rather than with dismissal.

If the cause of the problem is unclear, the supervisor should question the employee to find out why he is not performing well, e.g. is it a marital problem? etc. J. feels the supervisor has failed if the employee refuses a referral for treatment. The employee is not responsible to get help if he does not know he has a problem. Constructive coercion is not wrong if help was offered first and the situation has been well explained. J. advises that the supervisor should not tell the employee directly *"Change or be fired."* If the employee is motivated properly the supervisor is able to maintain a good relationship with him; i.e. confrontation must be a positive offer of help–coercion is secondary. J. emphasizes *"Don't force him–develop his sense of responsibility–respect him as a human being."*

Referral Process

J. notes that the referral must go through the senior manager. The supervisor may first try to help the employee on his own. However if a referral is required the supervisor should check with his senior manager and then refer directly to the staff nurse. J. would request consultation from the nurse, personnel director, senior manager, etc., i.e., someone within the organization.

Treatment Effectiveness

J. feels most people can be helped if they are willing to accept help. The supervisor benefits from the program through the fact that a problem employee becomes rehabilitated.

J. notes that he is not directly involved in the City program as he has not received a program description. Accordingly, his methods are very much his own within the context of the overall organization.

Interview No. 20

Departmental director of personnel with government employer. Immedate staff include one administrative technician who has two staff and a shared secretary.

Need for Program

Behavioral health problems are hard to recognize compared with general work performance and discipline problems. Behavioral health problems represent a minority of all performance problems. B. is aware of five or six cases out of 700 employees in the past year. He notes that *"probably a lot are covered up."* B. feels that supervisors don't have enough time and don't want to get involved. They have the attitude that *"It's his problem–not mine."* They also reason that *"I've got a problem . . . I can live with it . . . I don't want to make any more problems by confronting him."* Also, many supervisors are in the same union as their employees. *"They're switching away from caring about the individual."* They don't want to get involved.

B. believes that behavioral health problems are caused by shift work and by lack of a proper match between the job and the individual. The assistance program should consider the effect of work on the individual but this should not be used as an excuse for behavioral health problems. If the employee does not like his job he should ask to transfer or apply for another job. Some people take advantage of the income replacement plan; a husband and wife may book off sick on the same days. *"A person's job has become a human right."* Therefore it is difficult to fire an employee because the union argues that dismissal is unfair to the employee.

Method of Motivation

The employer is obligated to give the employee two chances. B. does not know if constructive coercion can be used for non-alcohol problems. He would expect the employee to volunteer that he has a problem and wants help. Utilization of the program depends on the supervisor's individual judgment. He should confront employees with their poor performance and ask why this is occurring. Then he should notify the personnel director. *"You can only rehabilitate an employee if he's willing to do it."* A good supervisor will try to get the employee rehabilitated before constructive coercion becomes a viable alternative. B. feels that *"the supervisor has nothing to lose"* by initiating action.

B. considers alcoholism as a physical disease and therefore amenable to constructive coercion. However, this approach is not the right thing to use with behavioral health problems. The program does not have many options in resolving behavioral health problems. B. notes that the supervisor often cannot identify behavioral health problems and this should be the doctor's job. B. also notes that unions do not condone abuse of sickness benefits. Therefore they would not object to the use of constructive coercion if the supervisor has sufficient documentation.

Referral Process

B. notes that it is easy for an employee to abuse doctor's certificates for extra sick leave. The program has no safeguards to prevent this. (The personnel director could get medical consultation from the company doctor but the doctor would need permission from the employee to communicate with the employee's doctor. This would probably be refused if the absence was not legitimate.) B. notes that treatment agencies do not work with the supervisor but tend to relate to fellow doctors. *"Our doctor has a socialist attitude,"* i.e., he tends to favor the employee in a conflict with the employer.

Interview No. 20, continued

Treatment Effectiveness

B. does not see coordination between the treatment agency and the work place as a very important factor in treament effectiveness. He sees treatment as a largely isolated function unless the illness has been caused by the work place.

Example of Problem Employee

A supervisor had documented an employee's poor performance and was ready to dismiss him. The employee admitted having an alcohol problem and thereby avoided being fired. He was sent to Henwood for treatment instead.

B. notes that behavioral health problems tend to reduce work performance. However, poor work performance is not necessarily indicative of a behavioral health problem.

Interview No. 21

Night Shop Foreman of Diesel Shop. Sixteen years with the company, eight as a supervisor. Is in a management level position directly responsible for crew foremen.

Example of Problem Employee

Situation

A clerk who is a member of AA bid in on a job in S.'s area. There was no ongoing alcohol problem although he was probably using some drugs. S. describes him as *"just a kid growing up."* S. was told the clerk was alcoholic and advised to keep an eye on him. However, he was given no information concerning his previous history. Accordingly, S. did not prejudge him. (He notes that he has no use for alcoholics if they try to BS him.)

S. had thirty days to assess the employee before accepting him permanently. The clerk was accepted because he did his work and was performing OK. A number of problems were noticed from the first week onward but the employee tried hard and could perform when pressured. S. describes him as possibly having some mental deficiency, suffering from insecurity who tended to engage in nonsensical discussions, worked slowly and created numerous false impressions. The employee told inconsistent stories which portrayed him as being tough. He was not crazy but lacking intelligence. Other supervisors tended to bait him into these discussions. S. describes him as a fair worker who was *"weird–just about the worst problem I had."*

Intervention

The employee was a nice kid who got along well and was liked by other staff; i.e. *"not as bad as we could have had."* Therefore, S. decided to keep him and used anger and direction to get him to produce.

Outcome

The employee bid out to a job in Calgary because he had relatives there. S. was not required to give a recommendation to his new supervisor.

Need for Program

The assistance progam is good business. There is some conflict between this and the company's obligation to help employees. Some supervisors cover up and tell intoxicated employees to sleep it off in a secluded spot. Employees with attitude problems are released (relatively) quickly. Alcohol problems are identified by timekeeping problems, smelling liquor on the breath and noting employee's failure to come in for work. In addition, supervisors keep an eye on known liquor caches and try to spot who's it is.

Approximately 25% of employees on the night shift have alcohol problems. There are many additional health problems. This occurs because many employees who get hurt on a section gang subsequently transfer to the shop. Health problems are often due to shift work because this is not a normal schedule and it hampers the individual's social life and creates family pressure. The value of the program lies in the fact that the supervisor obtains a rehabilitated employee.

Interview No. 21, continued

Method of Motivation

If a supervisor catches a fellow drinking he

1. sends him home;
2. takes an interrogated statement in the presence of a union representative;
3. offers referral to the alcoholism program;
4. requires that the employee correct the problem on his own if he refuses treatment;
5. if he does not improve another statement is taken;
6. After two or three statements are taken the employee has accumulated 60 "brownie points" and is subject to dismissal.

People who are really sick (alcoholism, mental illness or family problems) receive fewer brownies per statement. However, if they are playing games they receive up to 30 points per incident. Behavior change usually starts after 30 points are assessed. S. notes that one cannot motivate employees because they don't need the money so they don't need the job. He believes motivation is a very individual matter.

Referral Process

"I've never seen anyone who accepted referral for help." S. recalls confronting five alcoholic employees. One is no longer with the company. However, quite a few managers have accepted help although none of the tradesmen have done so. This may be because the job is more important to the managers. The official approach is identical for managers or workers.

S. is not sure of the steps in the referral process. Generally, the supervisor contacts a counsellor in the Alcoholism Committee. However, S. does not know the counsellor's role. He would refer an alcoholic employee to a senior manager or to an alcoholism committee member.

Treatment Effectiveness

S. does not know what treatment the program offers. He is aware of some sort of treatment offered on Vancouver Island which includes the involvement of doctors. The supervisor is not involved in the process after the initial confrontation. The intent is to treat the employee as a normal worker when he returns from treatment. S. does not know anyone who was effectively treated for alcoholism; i.e. does not know anyone who stayed on the wagon. He notes that treatment is a system to help control behavior. He has heard of this succeeding but has not seen it happen. He believes that treatment success depends on the individual's making a responsible decision. S. notes that his father is a long-time alcoholic. S. strongly endorses the program.

Second Example of Problem Employee

A Portuguese tradesman was identified as a problem in 1975 when he had a heart attack. An alcohol problem was identified one year ago. There are indications that this is a long-term alcoholic. He has been given more chances than most because he has heart problems and family problems. He is still drinking and does not admit

Interview No. 21, continued

his problem. When confronted with being drunk on the job some months ago and sent home he returned and came after the supervisor with a knife. He is now facing a court hearing. He should have been fired three months ago but no statement was taken due to his arrest. He was not fired previously because of the senior manager's incompetance; i.e. the manager is nearing retirement and is letting problems slide. Consequently, there is a lack of documentation and as a result, no basis for dismissal. There is still no indication that the employee wants help.

Interview No. 22

J. is in his thirties and has been with his company for eight years as a supervisor. He supervises 70 clerical staff on various shifts.

J. admits to an alcohol problem which is under some measure of control. He refused to have the interview taped.

Example of Problem Employee

An employee who is now sixty was transferred to J.'s supervision five years ago. The employee was a trained engineer and had been demoted three times–ending up as a non-op, due to his drinking problem.

Intervention

Treatment is not a viable option because the employee is not motivated and his health is seriously impaired (liver damage is irreversible). The employee has thirty-five years with the company and could be pensioned off. However, he does not wish to do so because he requires his full salary.

The superintendent wants the employee dismissed immediately due to the most recent episode of being intoxicated on the job. However, J. does not believe this is fair but is prepared to give him a letter stating that he will be fired next time. The employee has been given 50 demerit points and would automatically be fired if he receives any more demerits.

Need for Program

J. states he is unclear as to the company's policy on alcoholism. He believes senior management is too easy on the problem employee initially and is too tough later on. He feels the purpose of the program is not to cure alcoholism or fix broken marriages, etc. He believes the policy should be work oriented. The company has some obligation to help problem employees but J. feels most will respond to firm work standards being enforced. He believes most work performance problems are not related to behavioral health problems. He believes alcoholism does not affect performance except for resulting in poor attendance. He notes that absenteeism is not a major problem.

Method of Motivation

The supervisor should not use constructive coercion on his own, but only in consultation with senior management. J. defines constructive coercion as a threat of job loss for failure to accept treatment (rather than for continued poor work performance). J. recommends that management's disciplinary function be considered separately from the program's offer of help. Accordingly, the program consists entirely of a voluntary offer of help.

Referral for Treatment

J. feels *Antabuse* treatment should be offered on a totally voluntary basis–not as a condition of employment. He notes that Henwood has been used as a threat to alcoholic employees and states that this approach does not work. J. believes that treatment should not be a condition of employment. However, he is in favor of offering voluntary treatment to alcoholic employees. Good work performance should be the only criterion for continued employment.

Interview No. 23

B. is in his forties and has been with AGT for twenty-seven years, eight as a supervisor. He supervises eight tradesmen in the equipment installation section.

Need for Program

B. has been aware of one alcohol problem in his eight years as a supervisor. He believes many alcoholics are not identified as such. In the above instance, an employee was involved in a motor vehicle accident while driving an AGT vehicle. He was suspended for two weeks.

B. believes that behavioral health problems result in decreased work performance. However, decreased work performance does not reveal all behavioral health problems, e.g. marital problems may not affect work performance. B. notes that the program outlines a policy with regard to problem employees but makes no provision for excluding problem employees from being hired. B. feels that the AGT program is not really operational.

Method of Motivation

B. sees the program as consisting of the following three steps:

1. The supervisor identifies a problem employee.
2. The supervisor draws the problem to the attention of his immediate superior.
3. The medical department becomes involved.

Referral for Treatment

B. feels that a professional counsellor is needed in the program in order to make help more accessible to employees. Currently, the medical department consists of a nurse with an RN. Her function and training is not that of a counsellor. B. is not aware of any procedure for coordinating the treatment agency in the community with the work place.

Interview No. 24

D. is a Section Manager in the equipment installation section. He is in his fifties and has been with AGT for thirty years, twenty as a supervisor. He is a senior manager but has retained union membership. He supervises seven junior supervisors.

Example of Problem Employee

This was a good employee in his thirties who was alcoholic and had family problems. D. used constructive coercion and the employee accepted treatment. He was OK until he came under the responsibility of another supervisor. He has subsequently been dismissed.

Need for Program

D. agrees that alcoholism is an illness and sees the alcoholism program as part of the fringe benefit package. He notes that the union (IBEW) is responsible for obtaining fringe benefits. Consequently, the union is interested in maintaining an assistance program. D. notes that the union does not protect poor employees and does not grieve disciplinary action which is properly documented.

However, D. believes that most problems are not health related. He notes that many work performance problems among his staff are due to immaturity; i.e. the average age of 77 field workers is twenty-three.

Method of Motivation

D. believes it is important to convince the employee that he has a problem. This is done through normal work performance appraisals and disciplinary action. Accordingly, coercive methods are not needed. D. sees the program as a good resource but believes the supervisor should attempt to solve the problem on his own first. He notes that autocratic supervision is no longer used. However, he has reverted to this style and finds that it works. He notes that *"You have authority if you use it."* He believes a supervisor obtains the respect of his employees by getting results. He also notes that manpower planning is needed in order to prevent excessive work performance problems from developing.

Referral for Treatment

D. does not consider the medical department as a good resource in dealing with problem employees. He believes the supervisor requires a competent counsellor as a resouce, as opposed to nurses available through the medical department. He also notes that the counsellor should be a professional rather than a senior manager.

Referrals for treatment should be made directly by the supervisor or through an employee assistance counsellor if one is available. (D. did not indicate this on the questionnaire because the company has no counsellor.)

D. does not see coordination between the treatment agency and the work place as important. He notes that AGT is willing to cooperate wherever this is appropriate. However, he believes treatment should be effective in its own right.

D. believes the company should have a psychiatrist on its staff to serve as a resource to supervisors. Currently, supervisors have no clinical consultation available to them.

Interview No. 25

T. is in his thirties and has been with AGT for 17 years, four as a supervisor. He supervises two employees and is classified as a foreman.

Need for Program

T. believes that saving money is an important reason for implementing a program. However, he sees this as compatible with the employer's moral obligation to provide assistance to troubled employees. He also considers the program as a tool for improving the quality of supervision.

He believes that behavioral health problems results in poor work performance. However, senior management seems to pretend that behavioral health problems do not exist.

T. believes that the work situation often contributes to behavioral health problems because of the requirement that employees travel to various work sites. This leads to family stress, disrupted routines, etc. T. believes the program should address itself to unhealthy work situations as well as unhealthy employees although he acknowledges this may not be practical. He also believes that the quality of supervision is an important factor in the development of poor work performance.

T. has not had occasion to use the program. However, he would like to know the program better as a matter of personal interest.

Method of Motivation

If a problem exists, the supervisor is responsible to take action. This consists of:

1. talking to the employee;
2. referring him to senior management and personnel;
3. personnel refers the employee to the company nurse.

T. notes that the motivation of non-alcoholic behavioral health problems is difficult. He believes that an employee's failure to overcome poor work performance should not necessarily result in discipline or dismissal. Instead, the supervisor should examine the impact of the work situation and make additional efforts at resolving the problem. Dismissal should only be used as a last resort.

T. notes that *"You can't get people to do better by treating them progressively worse."* He stresses that the program needs a professional counsellor as a representative of the employer as well as professional resources in the community. He states that he would like to see a psychologist hired as an employee assistance counsellor in order to participate in recruitment, interviews and to accept referral of problem employees. He notes that a counsellor is needed so that the company will be able to treat the cause of the problem rather than only the symptoms. T. also emphasizes that the availability of a professional counsellor is important in that it allows the employer to offer help to the problem employee rather than simply obligating him to get help. In addition, the counsellor is needed to choose effective treatment resources for the problem employee.

Behavioral health problems result in decreased work performance but poor work performance does not necessarily indicate the presence of a behavioral health problem. T. feels that the program is basically a good one. However, there may be some stigma attached to employees who cooperate with the program. In addition, T. believes that supervisors should be required only to know how to access the program—not to understand the entire process. The presence of a counsellor would make this arrangement feasible and this would probably result in a greater utilization of the program.

Interview No. 26

D. is in his thirties and has been with AGT for sixteen years, four as a supervisor. D. is the foreman for nine employees–mostly apprentices.

Example of Problem Employee

This is a good employee who is in his fourth year of apprenticeship at NAIT. He studies hard and has excellent practical skills but *"seizes up in exams."* Consequently, the employee has failed his second and third years and has been granted extra opportunities to redo the course. (He requires successful completion of the course in order to qualify for a promotion. The course is sponsored by AGT.)

D. has involved his own supervisor in this problem. He has argued in favor of extra opportunities being given to the employee by AGT. In order to keep the employee in the program, D. has *"gone out on a limb"* and guaranteed that he will succeed. At this point D. believes that he requires outside help. He intends to contact personnel to find out if any resources are available beyond the company itself. (He apparently has no awareness of the assistance program as a viable resource for this employee.) D. questioned whether the U of A Extension program might have a course which would benefit the employee or whether the medical department might have something to offer.

Need for Program

D. notes that his area employs a lot of young people and that heavy alcohol consumption is prevalent. He believes that AGT has a moral obligation to assist its employees. On a personal basis, he states that he does not like to ignore a problem which is affecting one of his staff. However, D. sees the program as being limited strictly to alcohol and drug problems.

D. believes that the travel involved in the job is responsible for the development of family and personal problems.

Method of Motivation

D. believes that constructive coercion works because alcoholics do not know they have a problem and become aware of this through coercive techniques. However, he does not believe that all problem employees benefit by being identified as such. He argues that this may result in dismissal whereas job retention is always in the employee's best interests.

Referral for Treatment

D. believes that acceptance of treatment may have the effect of confirming that the employee has a problem. This could lead to discrimination against him in the future. D. feels that supervisors have good support from senior management. However, they need more information regarding the use of the program. He considers the program's greatest strength the fact that it exists. However, he does not believe the supervisor should be responsible for carrying out the entire program by himself.

Interview No. 27

H. is in his thirties and has been with AGT for fourteen years, three as a supervisor. He supervises ten apprentices in equipment installation.

Example of Problem Employee

This female employee was a good worker but was frequently late and had an attitude problem which resulted in a personality conflict with H. *"She tried to prove she could beat me."* H. saw this as a personal challenge and described the problem as a power struggle.

H. stated that he had talked to the employee about the problem on many occasions. A letter of reprimand was sent and the employee was eventually suspended for one day. This had the effect of restoring the employee's performance to a fully satisfactory level. H. notes that it is very important for the supervisor to establish his authority.

Need for Program

From senior management's point of view the program exists to protect the employer's investment. However, from H.'s own view the supervisor has a moral obligation to provide assistance to troubled employees. He also believes that the employee is morally obligated to resolve his or her performance problem and its underlying cause. He believes that most work performance problems are due to a general attitude toward work. Employees are less committed to their jobs because there is less need for security now than in the past. In addition, the power of the unions and human rights legislation tend to mitigate against the work ethic. He notes that it is hard to prove poor work performance and that lower standards have become the accepted norm.

Method of Motivation

H. feels that the unions tend to undermine the employer's disciplinary options. In addition, senior managers are too far removed from the problem and are not committed to firm discipline. He also believes that a threat of job loss cannot be used initially although it is a legitimate last resort in resolving work performance problems. H. believes that education is important in operationalizing the program. The program should be interpreted as helpful rather than a *"big stick"* wielded by management. H. feels there is a low level of awareness of the program among supervisors.

Referral for Treatment

H. believes that the medical department is not qualified as a resource to the program. He feels an employee assistance counsellor is needed as the prime resource.

H. believes the program should address itself strictly to poor work performance. However, this should be defined to include the problem employee's effect on his fellow employees.